STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155511	A. BUILDING 00 B. WING	05/24/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TERRE HAUTE NURSING AND REHABILITATION CENTER	830 S 6TH ST TERRE HAUTE, IN 47807

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: May 20, 21, 22, 23, and 24, 2019. Facility number: 000446 Provider number: 155511 AIM number: 100288720 Census Bed Type: SNF/NF: 26 Total: 26 Census Payor Type: Medicare: 1 Medicaid: 25 Total: 26 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on May 31, 2019.	F 0000	This visit was for a Recertification and State Licensure Survey. Survey dates: May 20, 21, 22, 23, and 24, 2019. Facility number: 000446 Provider number: 155511 AIM number: 100288720 Census Bed Type: SNF/NF: 26 Total: 26 Census Payor Type: Medicare: 1 Medicaid: 25 Total: 26 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on May 31, 2019	
F 0623 SS=D Bldg. 00	483.15(c)(3)-(6)(8) Notice Requirements Before Transfer/Discharge §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge;			

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	(iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure			

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	In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). Based on record review and interview, the facility failed to ensure a notice of transfer and discharge was provided to the resident or responsible party with hospital transfers (Residents 6 and 20), for 2 of 2 residents reviewed for hospitalizations. Findings include: 1. Resident 6's record was reviewed on 5/21/19 at 11:07 a.m. A quarterly Minimum Data Set (MDS) assessment, dated 2/28/19, indicated the resident had moderate cognitive deficit. Diagnoses on the resident's profile included, but were not limited to, transient cerebral ischemic attack unspecified (a brief episode of neurological dysfunction caused by loss of blood flow in the brain, spinal cord, or retina, without tissue death). A nurse's note, dated 5/11/19 at 6:50 a.m., indicated a Certified Nurse Assistant (CNA) approached nurse stating the resident was not acting right. Upon assessment, the resident was unable to communicate with staff, but was able to follow simple commands (squeeze hands, stick out tongue), and his pupils were fixed. The physician was notified and an order received to send to emergency department (ED) for evaluation and treatment.	F 0623	**F623** **483.15(c) (3)-(6) (8)** **Notice Requirements of Before Transfer/Discharge** **How will the corrective action be accomplished for those residents who are affected by this alleged deficient practice?** Residents 6 & 20 were given the Notice of Discharge/Bed Hold/Request hearing Form **How will the facility identify residents having the potential to be affected by the same deficient practice?** Facility to audit discharges in the last 30 days to ensure residents/families received the Notice of Discharge/Bed Hold/Request Hearing Form. **What measures were put into place or systematic changes made to ensure the deficient practice not recur?** The bed hold/readmission policy and the Bed Hold & In-House Transfer Policy form will be added to the resident transfer packets, with a check off list to ensure all necessary document are included.	06/23/2019

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	A nurse note, dated 5/11/19 at 11:35 a.m., indicated the resident being admitted to the hospital. The record lacked documented evidence that a notice of transfer or discharge had been provided to the resident or responsible party. During an interview, on 5/21/19 at 9:42 a.m., Resident 6 indicated he could not remember the facility giving him any paperwork when he was sent out to the hospital. 2. Resident 20's record was reviewed on 5/22/19 at 2:20 p.m. A quarterly Minimum Data Set (MDS) assessment, dated 4/18/19, indicated the resident had severe cognitive deficit. Diagnoses on the resident's profile included, but were not limited to, unspecified hydronephorosis (a condition of excess urine accumulation in kidneys), and calculus of kidney (often called a stone, is a concretion of material, usually mineral salts, that forms in an organ or duct of the body). A nurse's note, dated 5/13/19 at 9:10 a.m., indicated the physician was at the facility to see the resident and ordered her to be sent out to hospital emergency department (ED) due to complaints of abdominal pain and vaginal bleeding. A nurse's note, dated 5/13/19 at 9:35 a.m., indicated ambulance arrived to pick up the resident. No documentation of transfer paperwork being provided was observed. A nurse's note, dated 5/13/19 at 4:50 p.m., indicated hospital called the facility and indicated		All residents going on therapeutic leaves will be given the Bed Hold & In-House Transfer policy to review/sign prior to leaving the facility. If applicable the Resident representative will be provided with the said from for their review/signature. All licensed nurses were in-serviced on 5/22/19 in regards to adequate documentation as it relates to resident/responsible party being provided with the Notice of Transfer/Discharge. **How will the facility monitor its corrective action?** The DON or designee will conduct weekly audits for any changes, based on resident transfers/discharges for four weeks and monthly for six months thereafter until compliance is maintained for two consecutive quarters. The results of these audits will be reviewed by the QAPI committee monthly. If 95% compliance is not achieved, an action plan will be developed and implemented. Monthly QAPI minutes and action plans are submitted to the regional operations staff and corporate risk management for review. **Date Completed: June 23, 2019**	

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	the resident being admitted. The record lacked documented evidence that a notice of transfer or discharge had been provided to the resident or responsible party. During an interview, on 5/21/19 at 11:48 a.m., the MDS Coordinator indicated the nurses would complete transfer paperwork and bed hold policy and provide it to the ambulance service to give to the hospital staff. She was unsure if a copy of the paperwork had been provided to the resident or representative. During an interview, on 5/22/19 at 1:48 p.m., the Social Services Director (SSD) indicated, upon transfer, the nurse would print off a transfer/discharge document, and make a copy of the bed hold document, and give to the transport company. The resident/representative signed a copy of the bed hold document at admission that was kept in the resident's record. She did not believe that a copy of these items were provided to the resident or representative. During an interview, on 5/22/19 at 8:41 a.m., the Director of Nursing (DON) indicated the facility had not been providing a copy of the transfer/discharge notice or the bed hold policy to the resident and/or representatives at transfer. To the best of her knowledge, the facility did not have a policy to ensure this would be done. The facility would have to develop a policy and plan to ensure this would be done in the future. 3.1-12(a)(6)(A)(i) 3.1-12(a)(6)(A)(ii) 3.1-12(a)(6)(A)(iii)			

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F 0625 SS=D Bldg. 00	483.15(d)(1)(2) Notice of Bed Hold Policy Before/Upon Trnsfr §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. Based on record review and interview, the facility failed to ensure a bed hold policy was provided to the resident or responsible party with hospital transfers (Residents 6 and 20), for 2 of 2 residents reviewed for hospitalizations. Findings include:	F 0625	**F625** **483.15(d) (1) (2)** **Notice of bed-hold policy Before/Upon Transfer** **How will the corrective action be accomplished for those residents who are affected by this alleged deficient practice.**	06/23/2019

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	1. Resident 6's record was reviewed on 5/21/19 at 11:07 a.m. A quarterly Minimum Data Set (MDS) assessment, dated 2/28/19, indicated the resident had moderate cognitive deficit. Diagnoses on the resident's profile included, but were not limited to, transient cerebral ischemic attack unspecified (a brief episode of neurological dysfunction caused by loss of blood flow in the brain, spinal cord, or retina, without tissue death). A nurse's note, dated 5/11/19 at 6:50 a.m., indicated a Certified Nurse Assistant (CNA) approached nurse stating the resident was not acting right. Upon assessment, the resident was unable to communicate with staff, but was able to follow simple commands (squeeze hands, stick out tongue), and his pupils were fixed. The physician was notified and an order received to send to emergency department (ED) for evaluation and treatment. A nurse note, dated 5/11/19 at 11:35 a.m., indicated the resident being admitted to the hospital. The record lacked documented evidence that a bed hold policy had been provided to the resident or responsible party. During an interview, on 5/21/19 at 9:42 a.m., Resident 6 indicated he could not remember the facility giving him any paperwork when he was sent out to the hospital. 2. Resident 20's record was reviewed on 5/22/19 at 2:20 p.m. A quarterly Minimum Data Set (MDS) assessment, dated 4/18/19, indicated the resident had severe cognitive deficit.		Residents #6 and #20 were given the Notice of Discharge/Bed Hold/Request Hearing Form. **How will the facility identify residents having the potential to be affected by the same deficient practice?** Facility to audit discharges in the last 30 days to ensure residents/families received the Notice of Discharge/Bed Hold/Request Hearing Form. **What measures were put into place or systematic changes made to ensure the deficient practice not recur?** The bed hold/readmission policy and the Bed Hold & In-House Transfer Policy form will be added to the resident transfer packets, with a check off list to ensure all necessary document are included. All residents going on therapeutic leaves will be given the Bed Hold & In-House Transfer policy to review/sign prior to leaving the facility. If applicable the Resident representative will be provided with the said from for their review/signature. All licensed nurses were in-serviced on 5/22/19 in regards to adequate documentation as it relates to resident/responsible party being provided with the Notice of Transfer/Discharge **How will the facility monitor its corrective action?** The DON or designee will conduct weekly audits for any changes,	

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	Diagnoses on the resident's profile included, but were not limited to, unspecified hydronephorosis (a condition of excess urine accumulation in kidneys), and calculus of kidney (often called a stone, is a concretion of material, usually mineral salts, that forms in an organ or duct of the body). A nurse's note, dated 5/13/19 at 9:10 a.m., indicated the physician was at the facility to see the resident and ordered her to be sent out to hospital emergency department (ED) due to complaints of abdominal pain and vaginal bleeding. A nurse's note, dated 5/13/19 at 9:35 a.m., indicated ambulance arrived to pick up the resident. No documentation of bed hold paperwork being provided was observed. A nurse's note, dated 5/13/19 at 4:50 p.m., indicated hospital called the facility and indicated the resident being admitted. The record lacked documented evidence that a bed hold policy had been provided to the resident or responsible party. During an interview, on 5/21/19 at 11:48 a.m., the MDS Coordinator indicated the nurses would complete transfer paperwork and bed hold policy and provide it to the ambulance service to give to the hospital staff. She was unsure if a copy of the paperwork had been provided to the resident or representative. During an interview, on 5/22/19 at 1:48 p.m., the Social Services Director (SSD) indicated, upon transfer, the nurse would print off a make a copy of the bed hold document, and give to the		based on resident transfers/discharges for four weeks and monthly for six months thereafter until compliance is maintained for two consecutive quarters. The results of these audits will be reviewed by the QAPI committee monthly. If 95% compliance is not achieved, an action plan will be developed and implemented. Monthly QAPI minutes and action plans are submitted to the regional operations staff and corporate risk management for review. **Date Completed: June 23, 2019**	

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	transport company. The resident/representative signed a copy of the bed hold document at admission, that was kept in the resident's record. She did not believe that a copy of these items were provided to the resident or representative. During an interview, on 5/22/19 at 8:41 a.m., the Director of Nursing (DON) indicated the facility had not been providing a copy of the bed hold policy to the resident and/or representatives at transfer. On 5/22/19 at 8:52 a.m., the DON provided a document, dated 11/2002, titled, "Bed Hold and In-House Transfer Policy," and indicated it was the policy currently being used by the facility. The policy indicated, "...One copy each (signed and dated by the resident AND family member) must be given to the resident AND family member each time of transfer for hospitalization or therapeutic leave..." 3.1-12(a)(25)(A) 3.1-12(a)(25)(B) 3.1-12(a)(26)			
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on observation, record review, and interview, the facility failed to ensure nail care was provided for a resident who required assistance for 1 of 1 residents reviewed for activities of daily living (ADL's) (Resident 14).	F 0677	**F677** **483.24(a)(2)ADL CARE PROVIDED FOR DEPENDENT RESIDENT** **(a)(2) A resident who is unable to carry out activities of daily living receives the necessary**	06/23/2019

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	Findings include: On 5/20/19 at 12:13 p.m., Resident 14 was observed in the dining room, feeding himself. His fingernails, bilateral hands, were long with dark debris underneath them. On 5/21/19 at 9:10 a.m., the resident was observed with long fingernails, bilateral hands, with dark debris underneath them. On 5/22/19 at 10:30 a.m., the resident was observed with long fingernails, bilateral hands, with dark debris underneath them. On 5/23/19 at 11:47 a.m., the resident was observed up in the dining room with the Activity Director. His fingernails, bilateral hands, remained long with black debris underneath them. A scratched, bleeding area, was observed to the resident's left hand. The Activity Director took the resident to the Director of Nursing (DON) for treatment. Resident 14's record was reviewed on 5/23/19 at 10:15 a.m. A significant change Minimum Data Set (MDS) assessment, dated 3/15/19, indicated the resident had a severe cognitive impairment and required extensive assistance from one staff member for personal hygiene. Diagnoses included, but were not limited to, unspecified dementia (a group of thinking and social symptoms that interferes with daily functioning) with behavioral disturbance. A Certified Nursing Assistant (CNA) Skin Inspection Report, completed on shower days, dated 5/21/19, indicated the resident's fingernails		**services to maintain good nutrition, grooming, and personal and oral hygiene.** Resident #14 fingernails were cleaned, trimmed and filed. **How will the corrective action be accomplished for those residents who are affected by this alleged deficient practice?** All residents in the facility could potentially be affected by this practice. All residents requiring assist with ADLs will have their fingernails cleaned, trimmed, and filed immediately and on their respective shower day and as needed. **What measures were put into place or systemic changes made to ensure that the deficient practice not recur?** On 5/21/19 all nursing staff were in-serviced on nail care, including but not limited to trimming, filing and cleaning of resident fingernails during resident shower and as needed. An area to document nail care on the resident shower sheets were added. Electronic documentation for providing nail care was added to CNA's ADL documentation on the kiosks. **How will the facility monitor its corrective action?** To ensure compliance, the DON is responsible for the nail care QAPI audits weekly for four weeks and monthly for six months thereafter	

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	had not been clipped. A care plan, target dated 6/25/19, indicated the resident had an ADL self care performance deficit. Interventions included, but were not limited to, check nail length and trim and clean on bath day and as necessary. During an interview, on 5/23/19 at 12:00 p.m., the DON indicated she had put a dressing on the resident's hand earlier, but had not noticed if his fingernails were long or dirty. During an interview, on 5/23/19 at 1:40 p.m., the DON indicated fingernails should have been cleaned as needed and on shower days. A CNA was providing nail care to the resident at the time of the interview. On 5/23/19 at 2:33 p.m., the DON provided a document titled, "Care of Fingernails/Toenails," and indicated it was the policy currently being used by the facility. The policy indicated, "Purpose: The purposes of this procedure are to clean the nail bed, to keep nails trimmed, and to prevent infection...General Guidelines: 1. Nail care includes daily cleaning and regular trimming...4. Trimmed and smooth nails prevent the resident from accidentally scratching and injuring his or her skin...." 3.1-38(a)(3)		until compliance is maintained for two consecutive quarters. The results of the audits will be reviewed by the QAPI committee monthly. If 95% compliance is not achieved, an action plan will be developed and implemented. Monthly QAPI minutes and action plans are submitted to regional operations staff and corporate risk management for review. **Date Completed:** June 23, 2019	
F 0692 SS=D Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a			

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TERRE HAUTE NURSING AND REHABILITATION CENTER	830 S 6TH ST TERRE HAUTE, IN 47807

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	resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. Based on observation, record review, and interview, the facility failed to ensure the physician and guardian were notified, a care plan was reviewed and revised, and interventions were provided as indicated for a resident with significant weight loss for 1 of 1 residents reviewed for nutrition (Resident 14). Findings include: During a continuous lunch observation, on 5/23/19 from 12:07 p.m. to 12:26 p.m., Resident 14 was served a pureed (blended to a consistency of a creamy paste) diet in a divided plate. Applesauce was served in a separate container. The resident was not served or offered ice cream during the observation. Resident 14's record was reviewed on 5/23/19 at 10:15 a.m. A quarterly Minimum Data Set (MDS) assessment, dated 4/12/19, indicated the resident	F 0692	**F692** **483.25 (g) (1)-(3)** **Nutrition/Hydration Status Maintenance** **How will the corrective action be accomplished for those residents who are affected by this alleged deficient practice.** Dietary brought resident #14 ice cream to nurse after the noon meal. **How will the facility identify residents having the potential to be affected by the same deficient practice?** All resident tray line cared were checked to ensure they match current diet order and resident food likes and dislikes. **What measures were put into place or systematic changes made to ensure the deficient practice not recur?**	06/23/2019

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	had a severe cognitive impairment and a significant weight loss of 5% or more in the last month or 10% or more in the last six months, and was not on a physician prescribed weight loss program. Diagnoses on the resident's profile included, but were not limited to, mild intellectual disabilities, unspecified dementia (a group of thinking and social symptoms that interferes with daily functioning) with behavioral disturbance, and dysphagia (difficulty swallowing) unspecified. A physician's order, dated 2/1/19, indicated Boost liquid, one unit by mouth three times a day for nutritional supplement. A review of the resident's weights indicated the following: 3/12/19, 172.8 pounds. 4/5/19, 160.4 pounds 4/18/19, 160.8 pounds. 4/25/19, 160 pounds. 4/30/19, 164 pounds. 5/7/19, 159.6 pounds. 5/14/19, 155.4 pounds. 5/21/19, 157.8 pounds. The weight record lacked documentation the resident's physician or guardian were notified of the weight loss. Nurse's notes, dated 3/1/19 to 5/23/19, lacked documentation the resident's physician or guardian were notified of the weight loss. A care plan, last revised on 3/19/19, target dated 6/25/19, indicated the resident was at a nutritional risk and received a mechanical soft, no added salt (NAS) diet. Interventions included, but were not		On 5/28/19 all Dietary Staff were in-serviced on following diet orders to ensure residents are receiving proper nutrition and reading/following all resident meal tray cards to ensure that all proper supplements, etc are included on tray prior to leaving the kitchen. DON/designee to monitor weekly/monthly weights for significant weight losses. If a significant weight loss/gain is noted the DON/designee will monitor/discuss the resident's weight and nutritional status during the Nutrition At Risk (NAR) meeting that is held weekly. **How will the facility monitor its corrective action?** The DON/designee will conduct weekly audits for any significant weight changes, based on the findings of the Nutrition At Risk meetings weekly for four weeks and monthly for six months thereafter until compliance is maintained for two consecutive quarters. The results of these audits will be reviewed by the QAPI committee monthly. If 95% compliance is not achieved, an action plan will be developed and implemented. Monthly QAPI minutes and action plans are submitted to the regional operations staff and corporate risk management for review. **Date Completed: June 23, 2019**	

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	limited to, provide a regular diet as ordered last revised 5/22/17, provide chocolate milk and ice cream at lunch and dinner last revised 7/5/17, and weight and monitor results per facility policy last revised 3/23/17. The care plan lacked documentation of the resident's actual weight loss and the addition of new interventions related to the weight loss. A Nutrition Assessment by the RD, dated 4/12/19, indicated the resident had a significant weight loss, and an ideal body weight was between 160 and 196 pounds. A Recommendations Worksheet, dated 4/12/19, indicated the resident had a 7% weight loss in 30 days and recommended to discontinue the NAS diet and add ice cream with each meal. A physician's order, dated 4/13/19, indicated regular diet, pureed texture. A physician's order, dated 5/17/19, indicated Remeron (an antidepressant) 15 milligrams (mg) by mouth every evening for appetite. During an interview, on 5/23/19 at 1:40 p.m., the Director of Nursing (DON) indicated the Nutrition At Risk (NAR) meeting was held weekly and all residents with a significant weight loss were included. The physician and guardian should have been notified for any significant weight loss. When the resident was added to NAR a care plan should have been developed for the significant weight loss. The Remeron was recommended and put in place as a result of a NAR recommendation. During an interview, on 5/23/19 at 2:09 p.m., the DON indicated the RD assessed the resident on 4/12/19, and made the recommendation for ice			

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	cream at all meals. The resident normally had gotten the ice cream at meals, but they forgot to put it on his tray today. The consumption of the ice cream was not documented. The nutritional risk care plan was incorrect, it had not been revised. It should have been revised when the resident lost weight and was added to NAR. The resident was not receiving chocolate milk and ice cream at lunch and dinner, it was an old intervention, and should have been discontinued. She was unable to find documentation the physician and guardian were notified of the resident's weight loss. On 5/23/19 at 2:33 p.m., the DON provided a document titled, "Nutrition (Impaired)/Unplanned Weight Loss-Clinical Protocol," and indicated it was the policy currently being used by the facility. The policy indicated, "Assessment and Recognition: ...4. The staff will report to the physician significant weight gains or losses or any abrupt or persistent decline from baseline appetite or food intake. Cause Identification: 1. The physician will review possible causes of anorexia or weight loss with the nursing staff and/or dietitian before ordering interventions...Treatment/Management: 1. The staff and physician will identify pertinent interventions based on identified causes and overall resident condition, prognosis, and treatment wishes...." 3.1-46(a)(1)			
F 0757 SS=D Bldg. 00	483.45(d)(1)-(6) Drug Regimen is Free from Unnecessary Drugs §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary			

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	drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. Based on record review, and interview, the facility failed to ensure a resident's pulse was assessed when administering digoxin (a medication for heart failure and irregular heartbeat) and a digoxin level was completed for 1 of 5 residents reviewed for unnecessary medications (Resident 13). Findings include: Resident 13's record was reviewed on 5/21/19 at 11:02 a.m. An annual Minimum Data Set (MDS) assessment, dated 3/19/19, indicated the resident had a moderate cognitive impairment. Diagnoses on the resident's profile included, but were not limited to, unspecified atrial fibrillation (an irregular heartbeat that can lead to clots). A physician's order, dated 12/7/17, indicated	F 0757	**F757** **483.45 (d) (1)-(6)** **Drug Regimen is Free from Unnecessary Drugs** **How will the corrective action be accomplished for those residents who are affected by this alleged deficient practice.** Notified the physician that lab had not been done. New orders to check digoxin level next lab day and every 6 months thereafter and report results to MD **How will the facility identify residents having the potential to be affected by the same deficient practice?** All medication orders requiring lab work/monitoring were checked to ensure most recent administration	06/23/2019

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	digoxin (a medication for heart failure and irregular heartbeat) 125 micrograms (mcg) by mouth daily for unspecified atrial fibrillation and atrial flutter. The medication was to be held if the resident's pulse was less than 60. A physician's order, dated 3/6/18, indicated a digoxin level was to be checked. The physician's orders lacked documentation of any further orders for digoxin levels. A digoxin level, dated 3/6/18, indicated a level of 0.60, and a normal range of 0.9-2.0. The record lacked documentation of any further digoxin levels. A Medication Administration Record (MAR), dated March 2019, indicated digoxin was administered each day in the month. The record lacked documentation the resident's pulse was checked with any of the administrations. A MAR, dated April 2019, indicated digoxin was administered each day in the month. The record lacked documentation the resident's pulse was checked with any of the administrations. A MAR, dated May 2019, indicated digoxin was administered each day through 5/21/19. The record lacked documentation the resident's pulse was checked with any of the administrations. The vital signs section of the electronic record, dated 3/1/19 to 5/21/19, lacked documentation the resident's pulse was assessed with the digoxin administrations. A care plan, target dated 6/30/19, indicated the resident was on digoxin therapy related to atrial fibrillation. Interventions included, but were not		and lab work was done. **What measures were put into place or systematic changes made to ensure the deficient practice not recur?** On 5/22/19 all licensed nursing staff was in-serviced on monitoring/checking pulse prior to medications being administered, updated list of medications that require lab monitoring. Updated list of medications that require lab monitoring was placed in the nursing communication book and added to the nursing admission packet. DON will audit all new medication orders to ensure all medications requiring lab monitoring or scheduled for appropriate testing. **How will the facility monitor its corrective action?** The DON will conduct weekly audits on all new medication orders to ensure appropriate lab monitoring is completed as required weekly for four weeks and monthly for six months thereafter until compliance is maintained for two consecutive quarters. The results of these audits will be reviewed by the QAPI committee monthly. If 95% compliance is not achieved, an action plan will be developed and implemented. Monthly QAPI minutes and action plans are submitted to the regional operations staff and corporate risk management for review. **Date Completed: June 23, 2019**	

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limited to, report to the physician if pulse falls below 60 or rises above 110 or if skipped beats or other changes in rhythm were detected, and serum digoxin levels monthly or as ordered by the physician.

A care plan, target dated 6/30/19, indicated the resident had a pacemaker related to atrial fibrillation. Interventions included, but were not limited to, monitor vital signs as ordered per the facility policy, record, and notify the physician of significant abnormalities.

During an interview, on 5/22/19 at 9:06 a.m., the Director of Nursing (DON) indicated the resident's pulse should have been checked and documented each time the digoxin was administered. The pulse should have been documented on the MAR. The most recent digoxin level she was able to find was from March 2018. She was unable to find a current physician's order for a digoxin level. She was not sure why the care plan said a digoxin level would be done monthly or as ordered by the physician. Monthly digoxin levels were not the facility policy.

During an interview, on 5/22/19 at 10:30 a.m., the DON indicated she had checked the chart and was unable to find any digoxin level since March 2018. She checked with the resident's physician, and the physician wanted digoxin levels to be done every 6 months. She was not sure why there had not been an order in place. The digoxin levels should have been done in September 2018 and March 2019, based on the every 6 months schedule, but had not been completed. The care plan should not have said a digoxin level would be completed monthly.

On 5/22/19 at 10:23 a.m., the DON provided a

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	document titled, "Administering Medications," and indicated it was the policy currently being used by the facility. The policy indicated, "Policy Statement: Medications shall be administered in a safe and timely manner, and as prescribed. Policy Interpretation and Implementation: ...3. Medications must be administered in accordance with the orders...11. The following information must be check/verified for each resident prior to administering medications: ...b. Vital signs if necessary...." On 5/22/19 at 10:23 a.m., the DON provided a document titled, "Integrated MedFacts Module," and indicated it was the drug information currently being used by the facility. The document indicated, "...Digoxin Tablets...Have blood work checked as you have been told by the doctor...Have your blood work (digoxin levels) checked...." 3.1-48(a)(3)			
F 0838 SS=C Bldg. 00	483.70(e)(1)-(3) Facility Assessment §483.70(e) Facility assessment. The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. The facility assessment must address or include:			

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	§483.70(e)(1) The facility's resident population, including, but not limited to, (i) Both the number of residents and the facility's resident capacity; (ii) The care required by the resident population considering the types of diseases, conditions, physical and cognitive disabilities, overall acuity, and other pertinent facts that are present within that population; (iii) The staff competencies that are necessary to provide the level and types of care needed for the resident population; (iv) The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and (v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services. §483.70(e)(2) The facility's resources, including but not limited to, (i) All buildings and/or other physical structures and vehicles; (ii) Equipment (medical and non- medical); (iii) Services provided, such as physical therapy, pharmacy, and specific rehabilitation therapies; (iv) All personnel, including managers, staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care; (v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and (vi) Health information technology resources,			

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	such as systems for electronically managing patient records and electronically sharing information with other organizations. §483.70(e)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach. Based on record review, and interview, the facility failed to complete a facility assessment which had the potential to affect 26 of 26 residents residing in the facility. Findings include: On 5/20/19 at 10:01 a.m., an entrance conference was held with the Administrator and Director of Nursing (DON). The facility assessment was requested. On 5/24/19 at 10:30 a.m., the documents provided by the Administrator at the entrance conference were reviewed. The documents lacked a facility assessment. During an interview, on 5/24/19 at 12:53 p.m., the Administrator indicated the facility assessment had not been completed. She was not aware it needed to be done, and was not sure how she had missed the requirement. There was no facility policy for the facility assessment.	F 0838	**F838** **483.70 € (1)-(3)** **Facility Assessment** **How will the corrective action be accomplished for those residents who are affected by this alleged deficient practice.** Administrator immediately completed the Facility Assessment. **How will the facility identify residents having the potential to be affected by the same deficient practice?** All residents have the potential to be affected by this alleged practice. **What measures were put into place or systematic changes made to ensure the deficient practice not recur?** Facility Assessment will be available at all times and reviewed/updated annually; Administrator in-serviced on 5/24/19 relating to the completion of the Facility Assessment. **How will the facility monitor its corrective action?** The Facility Assessment will be reviewed monthly. The results of these audits will be reviewed by the QAPI committee monthly. If	06/23/2019

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			95% compliance is not achieved, an action plan will be developed and implemented. Monthly QAPI minutes and action plans are submitted to the regional operations staff and corporate risk management for review. **Date Completed: June 23, 2019**	
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:			

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	(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which 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; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of			

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TERRE HAUTE NURSING AND REHABILITATION CENTER	830 S 6TH ST TERRE HAUTE, IN 47807

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	its IPCP and update their program, as necessary. Based on observation, interview, and record review, the facility failed to ensure gloves were worn during insulin administration during 1 of 1 random medication administration observation (Resident 3). Findings include: On 5/22/19 at 11:40 a.m., Licensed Practical Nurse (LPN) 6 administered Humalog (a rapid acting insulin) 100 units (u)/milliliter (ml), 25 u subcutaneously (SQ) (an injection into the fatty layer between the skin and muscle), bare-handed, without wearing gloves. At the same time, LPN 6 indicated she had made a mistake, and should have worn gloves to administer the injection. Resident 3's record was reviewed on 5/23/19 at 2:34 p.m. A physician's order, dated 12/7/17, indicated Humalog 100 u/ml, inject 25 u SQ three times a day if blood sugar is greater than 200, before meals. During an interview, on 5/23/19 at 2:33 p.m., the Director of Nursing (DON) indicated gloves should have been worn to administer insulin. On 5/23/19 at 2:40 p.m., the DON provided a document titled, "Subcutaneous Injections," and indicated it was the policy currently being used by the facility. The policy indicated, "Purpose: The purpose of this procedure is to provide guidelines for the administration of medication by subcutaneous injection...Steps in the procedure...2. Put on gloves...." 3.1-18(a)	F 0880	**F880** **483.80 (a) (1) (4) (e) (f)** **Infection Prevention & Control** **How will the corrective action be accomplished for those residents who are affected by this alleged deficient practice?** LPN caring for Resident 3 was in-serviced on the use of gloves immediately after it was brought to facility's attention. **How will the facility identify residents having the potential to be affected by the same deficient practice?** Staff in-serviced at the time of survey regarding glove use and monitoring initiated. **What measures were put into place or systematic changes made to ensure the deficient practice not recur?** All staff were in-serviced on5/22/19 relating to proper hand washing, standard precautions and infection control. All nurses were in-serviced 5/22/19 on proper subcutaneous injection administration. **How will the facility monitor its corrective action?** The DON/designee will conduct weekly return demonstrations for proper hand washing technique, monitor proper standard precaution use, and proper infection control prevention weekly for four weeks and monthly for six	06/23/2019

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			months thereafter until compliance is maintained for two consecutive quarters. The results of these audits will be reviewed by the QAPI committee monthly. If 95% compliance is not achieved, an action plan will be developed and implemented. Monthly QAPI minutes and action plans are submitted to the regional operations staff and corporate risk management for review. **Date Completed: June 23, 2019**	
F 0912 SS=D Bldg. 00	483.90(e)(1)(ii) Bedrooms Measure at Least 80 Sq Ft/Resident §483.90(e)(1)(ii) Measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms; Based on observation, interview, and record review, the facility failed to ensure adequate square footage of living space in a room with the potential to be occupied by 3 residents for 1 of 1 resident rooms reviewed for square footage. Findings include: During an entrance conference interview, on 5/20/19 at 10:01 a.m., the Administrator indicated there were no rooms with 3 people at the time. Room 11 had 3 beds in it, but they would only use that room for 3 people as a last resort. On 5/20/19 at 10:40 a.m., room 11 was observed to have 3 beds in the room. The room was occupied by 2 residents.	F 0912	**F912** **Bedrooms Measure at Least 80 sq. ft/Resident CFR(s): 483.90(e)(1)(ii)** **How will the corrective action be accomplished for those residents who are affected by this alleged deficient practice.** There were only 2 residents living in room #11 at the time alleged deficient practice. **How will the facility identify residents having the potential to be affected by the same deficient practice?** Any time there are more than two residents placed in this room, they have the potential to be affected by the alleged deficient practice.	06/23/2019

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	During a maintenance tour, on 5/24/19 at 10:00 a.m., room 11 was measured by the Maintenance Director. The current measurement of the room, indicated 14.4 feet x 16.2 feet which equaled 233.29 total square feet. The calculated square footage was 77.76 square feet of living space per bed. During an interview, on 5/24/19 at 10:09 a.m., the Maintenance Director indicated the regulations required 80 square feet of living space per resident. During an interview, on 5/24/19 at 10:22 a.m., the Administrator indicated the facility did not have a policy related to room size. They followed the Federal and State regulations. 3.1-19(l)(2)(A)		The room will continue to house only two residents until further clarification is received regarding the facility's ability to apply for the room waiver. **What measures were put into place or systematic changes made to ensure the deficient practice not recur?** Facility will apply for room waiver annually. Residents in Room 11 and any future Room 11 occupants, will be notified in writing regarding the waiver and potential outcomes of occupancy. **How will the facility monitor its corrective action?** Residents residing in these rooms will be monitored for potential negative outcomes as a result of the room size or number of residents in the room. Negative outcomes could include, but not limited to: privacy, personal belongings, and adequate nursing care. The social worker will use the QIS Resident Interview protocol to measure resident satisfaction with privacy, retention of personal belongings, and the adequacy of nursing care provided, by interviewing residents in waivered rooms monthly for six months and ongoing. The results of these interviews will be reviewed monthly by the QAPI committee overseen by the administrator and reviewed by corporate risk management. If a satisfaction threshold of 95% related to size of	

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			room or occupancy is not achieved an action plan will be developed to ensure resident satisfaction is achieved. Social Service Director will also continue to monitor the psychosocial well-being of the residents affected by this current alleged deficient practice. **Date Completed: June 23, 2019**	