STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155551	A. BUILDING 00 B. WING	05/07/2012

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ROLLING MEADOWS HEALTH CARE CENTER	604 RENNAKER ST LA FONTAINE, IN 46940

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F0000	This visit was for a Recertification and State Licensure Survey Survey dates: May 1, 2, 3, 4, and 7, 2012 Facility number: 000447 Provider number: 155551 AIM number: 100289950 Survey team : Linn Mackey, RN-TC Shelly Reed, RN Julie Call, RN (5/7) Virginia Terveer, RN (5/4 and 5/7) Deann Mankell, RN (5/1 and 5/2) Census Bed Type: SNF/NF: 101 Total: 101 Census payor type: Medicare: 10 Medicaid: 59 Other: 32 Total: 101 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed on May 14, 2012 by Bev Faulkner, R.N.	F0000	We as the facility are hereby respectfully requesting this agency to consider paper compliance for the following plan of correction as opposed to a post survey revisit. We are willing to submit any and all documentation as requested to assure our credible compliance with the deficient practices noted in the following CMS-2567. We are herby providing our plan of correction. Submission of this Plan of Correction does not constitute an admission to or an agreement with facts alleged on the survey report.Submission of this Plan of Correction does not constitute an admission or an agreement by the provider of the truth of facts alleged or corrections set forth on the statement of deficiencies. The Plan of Correction is prepared and submitted because of requirements under State and Federal law.Please accept this Plan of Correction as our credible allegation of compliance.	

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

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F0241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Based on observation, interview and record review, the facility failed to ensure residents were fed with dignity during dining for 2 of 2 random observations during meals affecting Resident #46. Findings include: 1. During supper observation on 5/2/12 at 5 p.m., CNA #3 was observed to provide total dining assistance to Resident #46 in the 200 hall dining room. Resident #46 was seated in a Broda chair with 2 other residents at the table. CNA #3 was seated between Resident #46 and another resident seated in a wheelchair. While providing assistance to Resident #46 with his left hand, CNA #3 was providing feeding assistance to another resident with his right hand. CNA #3 was observed to feed to Resident #46 using two sippy cups. On observation, CNA #3 was mixing food contents of pureed food on the plate with liquids from 2 separate cups,1	F0241	A referral was made to speech therapy for resident #46. Resident #46 is currently on Speech therapy caseload. Certified Nursing Assistant #1 and #3 were re-educated regarding feeding dignity and individuality. All residents residing in the facility who require assistant with meal consumption have the potential to be affected by this practice. The facility policy and procedure for Feeding a Resident was reviewed with no changed indicated. Nursing staff were re-inserviced by the Director of Nursing on the facility policy and procedure for Feeding a Resident. The DON and/or designee will randomly audit four meals a week for four weeks, then every other week for four weeks, then monthly thereafter. The audit will be documented on the CMS Mandatory Facility Task Pathway form Dining Observation. Any concerns noted will receive immediate follow-up. Monitoring will continue until substantial compliance is achieved as determined by the QA committee. The Director of Nursing report of monitoring will be forwarded to the Administrator for	06/06/2012

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	box of Enlive Wild Berry drink (nutritional supplement) and 1 can of Ensure (a high calorie liquid supplement) into each sippy cup and feeding the resident using the same spoon to mix all food and liquids together. CNA #3 was not observed to have measured the amount of fluid mixed into the cup and mixed with the pureed food. During an interview on 5/3/12 at 5:20 p.m., CNA #3 indicated the contents of each cup contained the following; Ensure, pureed chicken, pureed potatoes, pureed beets and Enlive Berry juice mixed into the two sippy cups. 2. During lunch observation on 5/3/12 at 11:19 a.m., CNA #1 was observed to provide total dining assistance to Resident #46 in the 200 hall dining room. Resident #46 was seated in a Broda chair with 2 other residents at the table. CNA #1 was seated between Resident #46 and another resident seated in a wheelchair. While providing assistance to Resident #46 with his left hand, CNA #1 was providing feeding assistance to another resident with his right hand. On observation, CNA #1 was mixing the		monthly QA review and plan of action will be adjusted accordingly.	

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	contents of pureed food which included; pork chop, sweet potatoes, spinach, and a sugar cookie with Ensure, Enlive and thickened lemonade into two separate sippy cups using the same spoon for all. CNA #1 was not observed to have measured the amount of fluid mixed into each cup and mixed with pureed food. During record review on 5/4/12 at 2:15 p.m., a care plan indicated Resident #46 was to have a diet consisting of thickened fluids to nectar thick consistency and a pureed diet. Enlive and Ensure as ordered. The resident to be fed by food by sippy cup. Resident #46's diagnoses included, but were not limited to; dysphagia (difficulty swallowing), senile dementia, vascular dementia, diabetes, and asthma. A MDS (Minimum Data Set), dated 3/15/12, indicated no BIMS (Brief Interview Mental Status) was able to be conducted for Resident #46. During an interview on 5/7/12 at 4:00 p.m., Speech Therapist #2 indicated Resident #46 would not consume food that was mixed with thickened water and preferred the sweetened foods mixed all together with Enlive			

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	and Ensure. Speech Therapist #2 did not provide any documentation to indicate Resident #46's intake had improved by mixing all the foods together. Speech Therapist #2 indicated Resident #46 has not had an evaluation of oral and pharyngeal swallowing function since 7/30/10. 3.1-3(t)			

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F0250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Based on record review and interview, the facility failed to assess the risk of suicide for 1 of 3 residents reviewed for accidents in a sample of 40 who met the criteria for accidents. Resident # 140 Findings include: Resident # 140's record was reviewed on 5/4/12 at 10:12 a.m. Resident # 140's current diagnoses included, but were not limited to history of bipolar and schizophrenia, hypertension, major multiple trauma and suicidal attempt status post bilateral open ankle fractures. Review of clinical records indicated an admission date of 4/13/12 Review of physician progress notes, dated 4/19/12, indicated status post fall due to a suicide attempt. Review of social services noted indicated no notes related to suicide attempt or evaluation of resident risk	F0250	A suicide risk assessment was complete for resident #140. Care plan and interventions were reviewed and revised as appropriate for resident #140. All residents who are at risk for suicidal ideations have the potential to be affected by this practice. A review of all current residents History and Physicals was completed by the Social Service Director to determine any further residents at risk for suicidal ideations. No further residents were determined to be at risk for suicidal ideations. The facility Suicide Threat policy and procedure was reviewed with revisions made as appropriate. The facility Social Service Director was re-inserviced on the facility Suicide Threat policy and procedure by the Corporate Social Services Consultant. The Social Service Director and/or designee will review the History of Physicals of all new admissions and/or prospective admissions to assess for individuals at risk for suicidal ideations. The Social Service Director will track the review of all new admission on the Tracking Log. Any residents with attempted suicide ideations prior to admission will be assessed utilizing the facility Suicide Risk Assessment	06/06/2012

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	for further attempts of suicide. During an interview with the Social Service Designee on 5/4/12 at 11:00 a.m., she indicated that she did not do a suicide risk assessment on the resident. She indicated that she had talked to the resident but she had not written any progress notes. During an interview on 5/7/12 at 1:30 p.m., the Director of Nursing indicated they do not have a policy for assessments but followed the RAI (Resident Assessment Instrument) Manual Chapter 4 3.1-34(a)		form by the Social Service Director and/or designee to determine the individuals' suicide risk. All residents identified at risk for suicidal ideations will have individualized interventions initiated in their plan of care. The Corporate Social Service Consultant and/or designee will audit all new admits bi-weekly for three months, then monthly for three months, then quarterly thereafter. The audit will be documented on the Consultant/Designee Audit Log. Any concerns noted will receive immediate follow-up. Monitoring will continue until substantial compliance is achieved as determined by the QA committee. The Social Service Director and the Corporate Social Service Consultant report of monitoring will be forwarded to the Administrator for monthly QA review and plan of action will be adjusted accordingly.	

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F0279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). Based on record review and interview, the facility failed to develop a care plan that addressed the risk of suicide for 1 of 3 residents reviewed in a sample of 40 who met the criteria for accidents. (Resident # 140) Findings include: Resident # 140's record was reviewed on 5/4/12 at 10:12 a.m. Resident # 140's current diagnoses included, but were not limited to;	F0279	A suicide risk assessment was complete for resident #140. Care Plan and interventions were reviewed and revised as appropriate for resident #140. All residents who are at risk for suicidal ideations have the potential to be affected by this practice. A review of all current residents History and Physicals was completed by the Social Service Director to determine any further residents at risk for suicidal ideations. No further residents were determined to be at risk for suicidal ideations. The facility Care Plan policy was reviewed and no changes were indicated. The facility Care Plan	06/06/2012

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	history of bipolar and schizophrenia, hypertension, major multiple trauma and suicidal attempt status post bilateral open ankle fractures. Review of clinical records indicated a admission date of 4/13/12. Review of physician progress notes, dated 4/19/12, indicated status post fall due to a suicide attempt. Review of the care plan indicated the resident uses psychotropic/hypnotic medications R/T history of injury to self with no interventions noted to assess or monitor for suicide attempt. During an interview with the Social Service Designee on 5/4/12 at 11:00 a.m., she indicated that she did not add interventions to the care plan about the risk for suicide. During an interview with LPN# 10 on 5/4/12 at 12:00 p.m., the LPN indicated she was monitoring the resident for wound care and watching her in case she leaves because she is a smoker and for signs of depression. During an interview on 5/4/12 at 12:05 p.m., CNA # 8 indicated they are monitoring resident for activities		policy directs employees to refer to the RAI manual Chapter 4. The facility Social Service Director was re-inserviced on the facility Care Plan (RAI manual Chapter 4) policy and procedure by the Corporate Social Services Consultant. The Social Service Director and/or designee will review the History of Physicals of all new admissions and/or prospective admissions to assess for individuals at risk for suicidal ideations. The Social Service Director will track the review of all new admission on the Tracking Log. Any residents with attempted suicide ideations prior to admission will be assessed utilizing the facility Suicide Risk Assessment form by the Social Service Director and/or designee to determine the individuals' suicide risk. All residents identified at risk for suicidal ideations will have individualized interventions initiated in their plan of care. The Corporate Social Service Consultant and/or designee will audit all new admits bi-weekly for three months, then monthly for three months, then quarterly thereafter. The audit will be documented on the Consultant/Designee Audit Log. Any concerns noted will receive immediate follow-up. Monitoring will continue until substantial compliance is achieved as determined by the QA committee. The Social Service Director and the	

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	of daily living assistance.. During an interview on 5/4/12 at 12:10 p.m. with CNA # 11, the CNA indicated they monitored the resident to make sure she did not but any weight on her feet. During an interview on 5/17/12 at 1:30 p.m., the Director of Nursing indicated they do not have a policy on care planning, but followed the RAI (Resident Assessment Instrument) Manual Chapter 4 3.1-35(a)		Corporate Social Service Consultant report of monitoring will be forwarded to the Administrator for monthly QA review and plan of action will be adjusted accordingly.	

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F0364 SS=E	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. Based on observation, interview and record review, the facility failed to ensure food was served at a palatable temperature for 6 of 17 residents interviewed with the potential to affect 19 residents receiving meal trays in their rooms. (Residents # 138, # 113, # 28, # 80, # 5, # 106) Findings include: 1. During resident interviews conducted on 5/1/12 and 5/2/12, 6 of 17 residents interviewed indicated food items were not served at proper temperatures. (Residents # 138, # 113, # 23, # 80, # 5, # 106) Interview with Resident # 80 on 5/1/12 at 10:43 a.m., indicated the food is sometimes cold. Interview with Resident # 106 on 5/1/12 at 1:37 p.m., indicated the food is served at too cold of temperature.	F0364	All residents who receive meal trays to their rooms have the potential to be affected by this practice. The facility policy and procedure for Temperature of Serving/holding Foods was reviewed with no changes indicated. The Dietary staff was re-inserviced on the facility policy and procedure for Temperature of Serving/holding Foods by the corporate Registered Dietician. The Dietary manager and/or designee will randomly audit a test tray temperature three times a week for four weeks, then three times a week every other week for four weeks, then monthly thereafter. The audit will be documented on the Tray Temperature documentation log. The Dietary manager and/or designee will randomly interview four residents who receive meal trays in their rooms weekly for four weeks, then every other week for four weeks, then monthly thereafter. The interview will be documented on the Resident Interview for Food Temperature form. Any concerns noted will receive immediate follow-up. Monitoring will continue until	06/06/2012

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	Interview with Resident # 28 on 5/1/12 at 2:30 p.m., indicated the food is not the proper temperature, it is late and it's cold. Interview with Resident # 5 on 5/1/12 at 3:01 p.m., indicated the food is not always served at the proper temperatures. Interview with Resident # 138 on 5/2/12 at 10:08 a.m., indicated, "It's cold." Interview with Resident # 113 on 5/2/12 at 1:35 p.m., indicated the food could be hotter. Interview with Dietary Manager #7 on 5/7/12 at 11:15 a.m., indicated she needed to refer to the policy for food temperatures guidelines. During observation on 5/7/12 at 11:20 a.m., a test tray was delivered to Hall 100 by Dietary Manger #7. The temperature of the food items were measured by Dietary Manager # 7 with the following recordings: Baked chicken-160 degrees; carrot coins-135 degrees; potato and pea salad-66 degrees; applesauce-46 degrees, and a carton of 2% milk-40 degrees.		substantial compliance is achieved as determined by the QA committee. The Dietary Manager report of monitoring will be forwarded to the Administrator for monthly QA review and plan of action will be adjusted accordingly.	

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	During interview with Dietary Manager #7, while measuring the food temperatures, she indicated the potato and pea salad is a cold salad. The potato and pea salad was served directly on the same plate with the hot food. The salad was noted to have a cream based dressing. The current policy "Monitoring Food Temperatures," dated 7/08, was received from Dietary Manager #7 on 5/7/12 at 11:35 a.m.. The document indicated ...Hot and cold food temperatures will be checked just prior to service time. The minimum acceptable temperatures for hot food is 135 degrees F. or above. The minimum acceptable temperatures for cold food is 41 degrees F. or below.... Interview with Dietary Manager # 7 on 5/7/12 at 2:15 p.m., indicated room trays were delivered to: nine (9) residents on 100 Hall who eat all of their meals in their room. One resident on 200 Hall who eats all of their meals in their room and one additional resident eats only breakfast in their room. Seven (7) residents on 300 Hall eat all of their meals in their room and one additional resident eats			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
	only breakfast in their room. No residents on 400 Hall eat in there room. 3.1-21(a)(2)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155551	A. BUILDING 00 B. WING	05/07/2012

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F0431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS 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. 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. 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. 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 drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation and interview, the facility failed to ensure the tubes and bottles of topical medications were properly labeled with resident	F0431	No residents were negatively affected by this practice. All residents who reside in the facility that receive individualized drugs and/or biologicals that are stored	06/06/2012

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	names for 7 of 42 medications reviewed stored in 3 of 6 medication carts. The facility also failed to properly label and dispose of insulin vials for 3 of 14 vials reviewed. Findings include: On 5/4/12 at 2:12 p.m., while observing medication storage, tubes and bottle of medicated ointments, creams and drops were found without labels to identify which resident the medication belonged or dates indicating when they were opened. There were five medication carts and one treatment cart containing tubes and bottles of medicated ointments and vials of insulin stored in wood medication carts. The treatment cart stored on Hall 300 contained the following tubes of ointment, creams and drops without resident specific label: two tubes of Bacitracin Ointment (topical antibiotic), M9 Ostomy drops (reduce odor in ostomy pouch), and Silvasorb (antimicrobial cream for wounds). The treatment cart contained the following tubes and creams without a specific date the medication was opened: Betamethasone (steroid cream for inflammation), Proctosol (cream to reduce inflammation).		by authorized personnel of the facility have the potential to be affected by this practice. The tubes and bottle of medicated ointments, creams, insulin, and drops found without labels to identify which resident the medication belonged or dates indicating when they were opened were removed from the medication and treatment carts and disposed of per facility policy and procedure. The facility policy and procedure for Storage and Expiration Dating of Medications, Biologicals, Syringes, and Needles reviewed with no changes indicated. The facility nursing staff was re-inserviced on the facility policy and procedure for Storage and Expiration Dating of Medications, Biologicals, Syringes, and Needles. The DON and/or designee will randomly audit medication and treatment carts weekly for four weeks, then every other week for four weeks, then monthly thereafter. The audit will be documented on the CMS Mandatory Facility Task Pathway Medication Storage form. Any concerns noted will receive immediate follow-up. Monitoring will continue until substantial compliance is achieved as determined by the QA committee. The Director of Nursing report of monitoring will be forwarded to the Administrator for monthly QA review and plan of action will be adjusted accordingly.	

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	The medication cart on Maple Lane contained 2 vials of insulin (medication to control blood sugar) without a date on the vials to identify when the vials were opened: The medication cart of Birch Lane contained 1 tube of Bacitracin Ointment and 1 vial of insulin without a specific date the medication was opened: Interview on 5/4/12 at 12:40 p.m., RN #5 indicated the representative from the contracted pharmacy was in the facility approximately two weeks ago to review medications. RN #5 indicated the medication should be dated when opened and should also contain a resident specific label. 3.1-25(j)			