STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155357	A. BUILDING 00 B. WING	07/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RAWLINS HOUSE HEALTH & LIVING COMMUNITY	300 J H WALKER DR PENDLETON, IN 46064

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00413620. This visit included a State Residential Licensure Survey. Complaint IN00413620 - No deficiencies related to the allegations are cited. Survey dates: July 24, 25, 26, 27, 28 & 31, 2023 Facility number: 000248 Provider number: 155357 AIM number: 100291470 Census Bed Type: SNF/NF: 90 SNF: 12 Residential: 53 Total: 155 Census Payor Type: Medicare: 17 Medicaid: 68 Other: 17 Total: 102 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed August 4, 2023.	F 0000	The plan of correction is to serve as Rawlins House Health and Living Community's credible allegation of compliance. Submission of this plan of correction does not constitute an admission by Rawlins House Health and Living Community or its management company that the allegations contained in the survey report is a true and accurate portrayal of the provision of nursing care and other services in this facility. Nor does this submission constitute an agreement or admission of the survey allegations. The facility respectfully requests desk review for the following citations.	
F 0554 SS=D Bldg. 00	483.10(c)(7) Resident Self-Admin Meds-Clinically Approp §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate.			

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

Chad Covey | HFA | 08/15/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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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	Based on observation, interview, and record review, the facility failed to evaluate residents for self-administration of medications prior to leaving medications unattended at the bedside for 2 of 7 residents reviewed for infection control. (Residents 255 and 315) Findings include: 1. During an interview at the time of a random observation on 7/24/23 at 11:18 a.m., Resident 39's family member came out of the resident's room with a medication cup that contained two pills. She indicated these pills were left on the resident's overbed table and she didn't know what the medications were for because the resident was also uncertain which medications were left in the medication cup. She took the medications to the nurse's station and gave them to an unknown male staff member, who indicated he would get the resident's nurse. During an interview on 7/24/23 at 2:50 p.m., a resident representative indicated he had been in the resident's room this morning when the nurse brought the resident her medications. The nurse administered part of the resident's medication, placed the medication cup with the last two pills on the resident's overbed table, then left the room to retrieve some chocolate milk. The resident representative had followed the nurse to get the chocolate milk. The nurse did not return immediately to the room to administer the remaining medications. The nurse returned to the room after a family member went to the nurse's station and asked about the medications left in the resident's room. During an interview on 7/24/23 at 4:06 p.m., LPN 5 indicated she left two pills at the resident's	F 0554	**F 554 Resident Self-Admin meds-Clinically appropriate** **I. What corrective actions will be accomplished for those residents found to have been affected by the practice?** Resident 255 has discharged home. Resident 315 has been assessed and is capable of self-administering medications. **II. The facility will identify other residents that may potentially be affected by the practice.** Other residents identified that self-administer medications will have assessment updated and added to the medical record. **III. The facility will put into place the following systematic changes to ensure that the practice does not recur.** Licensed Nurses are receiving education regarding the self-administration of medications policy. **IV. The facility will monitor the corrective action by implementing the following measures.** The DON, or designee, will audit residents identified to self-administer medications daily	08/16/2023

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	bedside on the overbed table this morning when she left the room to get the resident some chocolate milk. She would not typically leave medications in the resident's room while she retrieved other items, but she planned to come right back to the resident's room. Medications should not have been left unattended at the resident's bedside. Resident 255's clinical record was reviewed on 7/25/23 at 3:24 p.m. Diagnoses included oral phase dysphasia, essential primary hypertension and gastro-esophageal reflux disease without esophagitis. The clinical record lacked an order to self-administer medications, an intra-disciplinary team (IDT) note regarding medication self-administration, and a self-medication administration assessment prior to the interview with LPN 5 on 7/24/23. An admission Minimum Data Set (MDS) assessment, dated 7/20/23, indicated the resident had moderate cognitive impairment. A current care plan, dated 7/21/23, indicated the resident was unable to independently perform late loss activities of daily living. Interventions included the following: monitor for swallowing issues, report any issues, and provide assistance and encouragement. During an interview on 7/28/23 at 11:32 a.m., the DON indicated the following items should have been in place before medications were left at the resident's bedside: medication self-administration assessment, the IDT meeting note, and the physician's agreement for medication self-administration. 2. During an observation on 7/26/23 at 2:18 p.m., Resident 315 had an albuterol (to treat asthma/COPD) rescue inhaler and a		for 14 days, then weekly for 6 weeks, then monthly for 3 months, then quarterly ongoing through quality assurance. Results of these audits will be reviewed in the facility Quality Assurance Meeting which is held monthly and overseen by ED. Results of this audit will be reviewed at the Quality Assurance meeting and frequency and if a threshold of 100% is not achieved, the audits and frequency will be adjusted as needed.	

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	Trelegy Ellipta (to treat asthma/COPD) inhaler on his bedside table. On 7/27/23 at 9:13 a.m., he was observed with an albuterol rescue inhaler and a Trelegy Ellipta inhaler on his bedside table. On 7/27/23 at 1:38 p.m., he was observed with an albuterol rescue inhaler and a Trelegy Ellipta inhaler on his bedside table. Resident 315's clinical record was reviewed on 7/27/23 at 11:03 a.m. His diagnosis included chronic obstructive pulmonary disease (COPD), chronic respiratory failure, and COVID-19. A physicians order, dated 7/21/23, indicated albuterol sulfate inhaler 90 microgram (mcg); administer two puffs by inhalation, every six hours as needed (PRN). A physicians order, dated 7/22/23, indicated Trelegy Ellipta inhaler; 100-62.5-25 mcg; administer one puff by inhalation, once a day, upon rising between 7:00 a.m.- 11:00 a.m. Resident 315's physicians orders lacked an order for self administration, and the resident's clinical record lacked a self administration assessment or a self administration care plan. During an interview, on 7/26/23 at 2:18 p.m., the resident indicated the nurse practitioner was aware he had these medications at his bedside. He took the albuterol for his rescue inhaler and the Trelegy was for him to take at night before bed. During an interview, on 7/27/23 at 1:50 p.m., the DON indicated for a resident to have medications at bedside, the facility would need to complete a			

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	self administration assessment and obtain a physician's orders. She indicated that Resident 315's medication was left at his bedside to prevent his medications from being on the nursing cart since he was positive for COVID-19. Review of a current, revised December 2012, policy, titled "Administering Medications", provided by the Corporate Nurse Consultant on 7/27/23 at 3:25 p.m., indicated the following: "...Policy Interpretation and Implementation...24. Residents may self-administer their own medications only if the Attending Physician, in conjunction with the Interdisciplinary Care Planning Team, has determined that they have the decision making capacity to do so safely...." 3.1-11(a)			
F 0656 SS=D Bldg. 00	483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) 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 §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40			

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	but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. Based on interview and record review, the facility failed to develop and/or implement a comprehensive care plan regarding communication for a resident with hearing loss for 1 of 21 residents review for care plan development and implementation. (Resident 3) Finding Includes: During an interview on 7/24/23 at 3:42 p.m., Resident 3 indicated she had been evaluated for	F 0656	**F 656 Develop/implement comprehensive care plans** **I. What corrective actions will be accomplished for those residents found to have been affected by the practice?** Resident plan of care updated, and Audiologist notified.	08/16/2023

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	hearing aides and had not heard any update regarding them. Many times, when she received care from staff, she had to ask them to repeat themselves. On Wednesdays, she played piano to accompany a gentleman who came to the facility and sang. It became difficult to hear the hymn number he announced and she had to ask him to repeat the number. She felt frustrated when she had to ask him to repeat himself. She missed most of the conversations at lunch because the female resident she sat with had a soft voice. She was anxious to receive her hearing aids and not have to ask everyone to repeat themselves. Resident 3's clinical record was reviewed on 7/25/23 at 3:28 p.m. Diagnoses included Parkinson's disease, major depressive disorder, and anxiety disorder. An audiologist's assessment, completed on 2/23/23, indicated the resident had complained of newly decreased ability to hear. The clinical findings of the assessment indicated a moderate to profound hearing loss to the resident's left ear and moderate to severe hearing loss in the resident's right ear. Recommendations for the attending physician and/or nursing staff included, to use slow, clear speech using visual cues when communicating and to favor the resident's right ear. Hearing aids were recommended for both ears and impressions for the hearing aids were obtained. The resident's care plan lacked any plan regarding resident's hearing deficit or to address the resident's hearing loss while awaiting the delivery of hearing aids. During an interview on 7/26/23 at 11:42 a.m., the Social Services Director (SSD) indicated he had		**II. The facility will identify other residents that may potentially be affected by the practice.** Facility will review audiology recommendations from the current calendar year and update care plans, as necessary. **III. The facility will put into place the following systematic changes to ensure that the practice does not recur.** The IDT is being educated regarding implementation of audiology recommendations and updating the plan of care. **IV. The facility will monitor the corrective action by implementing the following measures.** The DON, or designee, will audit residents receiving audiology services and ensure the care plan is updated daily for 14 days, then weekly for 6 weeks, then monthly for 3 months, then quarterly ongoing through quality assurance. Results of these audits will be reviewed in the facility Quality Assurance Meeting which is held monthly and overseen by ED. Results of this audit will be reviewed at the Quality Assurance meeting and frequency and if a threshold of 100% is not achieved, the audits	

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	become frustrated with the provider due to the lack of a delivery date. He had reached out several times to request a status of the resident's hearing aids and had not been given an estimated date of delivery. He understood the resident's anxiety regarding the lengthy wait for delivery. During an interview on 7/26/23 at 2:27 p.m., CNA 4 indicated she was not aware the resident was hard of hearing. She had not noticed difficulty during Resident 3's care, but was familiar with care for those who were hard of hearing. On 7/31/23 at 11:36 a.m., the Administrator provided a copy of the current, revised 12/2016, facility policy titled, "Care Plans, Comprehensive Person-Center." The policy indicated the following: "...Policy Interpretation and Implementation...8. The comprehensive, person-centered care plan will:...g. Incorporate identified problem areas;...10. Identifying problem areas and their causes, and developing interventions that are targeted and meaningfulto [sic] the resident, are the endpoint of the interdisciplinary process...." 3.1-35(a)		and frequency will be adjusted as needed.	
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were			

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	unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Based on observation, record review, and interview, the facility failed to follow a physician's order for bilateral pressure relief boots for a dependant resident for 1 of 3 residents reviewed for pressure ulcers. (Resident 100) Finding includes: During an observation on 7/25/23 at 9:22 a.m., Resident 100 was laying in bed, barefoot, with a bandage dated "7/25" to the top and left side of his left foot. His heels rested on the bed and no pressure relief boots were in place. On 7/26/23 at 9:19 a.m., he was observed laying in bed wearing socks and his heels rested on the bed. He had no pressure relief boots on. On 7/27/23 at 8:30 a.m., he was observed sitting up in bed, barefoot, with his heels rested on the bed. He had no pressure relief boots on. Resident 100's clinical record was reviewed on 7/26/23 at 2:35 p.m. His diagnoses included fracture to unspecified part of neck of left femur, unspecified fracture of left tibia, unspecified fracture of shaft of left fibula, and unspecified fracture of T11-T12 vertebra. A MDS (Minimum Data Set) assessment, dated 6/22/23, indicated he required extensive assistance with bed mobility and transfers. Walking did not occur.	F 0686	**F 686 Treatment/Svcs to prevent /heal pressure ulcer** **I. What corrective actions will be accomplished for those residents found to have been affected by the practice?** Resident discharged to home. **II. The facility will identify other residents that may potentially be affected by the practice.** Other residents with physician orders for bilateral pressure relief boots are being reviewed to ensure that physician orders are being followed. **III. The facility will put into place the following systematic changes to ensure that the practice does not recur.** Licensed Nurses receive education on proper documentation, monitoring, and notification of physician orders and refusals. **IV. The facility will monitor the corrective action by**	08/16/2023

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	He had current physician's orders (5/31/23) to elevate/offload heels while in bed as tolerated and (6/1/23) for bilateral heel float boots when in bed. A review of the electronic medication administration record (eMAR) for July 1, 2023-July 27, 2023 indicated Resident 100 wore his bilateral heel float boots daily. During an interview on 7/26/23 at 2:03 p.m., the resident indicated he had not worn pressure relief boots to his feet in weeks and there were no boots for his feet in his room. During an interview on 7/27/23 at 2:04 p.m., RN 3 indicated Resident 100 did not have boots on and refused to wear them. When treatments were refused, staff were to document refusals in the clinical record and report to the physician. During an interview on 7/27/23 at 2:36 p.m., the DON indicated Resident 100 used to wear bilateral pressure relief boots when first admitted to the facility, but no longer wore them. She should have discontinued his order for pressure relief boots. Review of a current facility policy, effective 4/3/17 and titled " Protocol for Following Physician Orders", provided by the Corporate Nurse Consultant on 7/27/23 at 3:51 p.m., indicated the following: "...Procedure: All licensed staff will verify and follow the physician orders as written. If for any reason, the physician order cannot be followed, the professional will contact the physician for further instructions. Care Plan: The resident's plan of care will reflect the physicians orders and direction for the resident's plan of care...."		**implementing the following measures.** The DON, or designee, will audit residents with physician orders for pressure reducing boots to ensure physician orders are being followed for 14 days, then weekly for 6 weeks, then monthly for 3 months, then quarterly ongoing through quality assurance. Results of these audits will be reviewed in the facility Quality Assurance Meeting which is held monthly and overseen by ED. Results of this audit will be reviewed at the Quality Assurance meeting and frequency and if a threshold of 100% is not achieved, the audits and frequency will be adjusted as needed.	

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R 0000 Bldg. 00	3.1-40(a)(2) This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey and Investigation of Complaint IN00413620. Complaint IN00413620 - No deficiencies related to the allegations are cited. Survey dates: July 24, 25, 26, 27, 28 & 31, 2023 Facility number: 000248 Residential Census: 53 Rawlins House Health & Living Community was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey. Quality review completed August 4, 2023.	R 0000	The plan of correction is to serve as Rawlins House Health and Living Community's credible allegation of compliance. Submission of this plan of correction does not constitute an admission by Rawlins House Health and Living Community or its management company that the allegations contained in the survey report is a true and accurate portrayal of the provision of nursing care and other services in this facility. Nor does this submission constitute an agreement or admission of the survey allegations. The facility respectfully requests desk review for the following citations.	