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	07/12/2023

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

(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 the Investigation of Complaints IN00411402, IN00411619, and IN00411859. Complaint IN00411402 - No deficiencies related to the allegations are cited. Complaint IN00411619 - Federal/State deficiencies related to the allegations are cited at F684. Complaint IN00411859 - Federal/State deficiencies related to the allegations are cited at F684. Survey dates: July 11 and 12, 2023. Facility number: 000248 Provider number: 155357 AIM number: 1002911470 Census Bed Type: SNF/NF: 91 SNF: 16 Total: 107 Census Payor Type: Medicare: 26 Medicaid: 67 Other: 14 Total: 107 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed July 17, 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 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Chad Covey	HFA	07/20/2023

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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	Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on interview and record review, the facility failed to document, monitor, and notify the physician regarding a medication error event for 1 of 1 resident reviewed for IV (intravenous) medications (Resident C). Findings include: Resident C's clinical record was reviewed on 7/11/23 at 10:20 a.m. Diagnoses included osteomyelitis, hyperkalemia, essential (primary) hypertension and chronic kidney disease, stage 3. Her physician orders included cefepime (antibiotic) in dextrose 5% piggyback 1gm/50 ml gram/milliliter via IV every 12 hours, 1 liter of normal saline at 75 ml/hr (milliliters/hour) immediately on 6/13/23, and vancomycin (antibiotic) 1000 mg via IV every 12 hours at 10:00 a.m. and 10:00 p.m. A nurse practitioner progress note, dated 6/14/23, indicated per nursing, the vancomycin was administrated quicker than the one hour administration time due to an IV pump error. No adverse effects were noted from the vancomycin. Repeat labs were ordered and were pending. No rash was noted. She denied any swallowing issues. Continue to monitor closely. She did not appear to be in any distress.	F 0684	**F 684 Quality of Care** **I. What corrective actions will be accomplished for those residents found to have been affected by the practice?** Resident no longer resides at Facility. The nurse involved will has been educated. **II. The facility will identify other residents that may potentially be affected by the practice.** Other residents receiving IV medications are being audited. Facility will document, monitor, and notify physician of any medication errors identified. **III. The facility will put into place the following systematic changes to ensure that the practice does not recur.** Licensed Nurses are receiving education on proper documentation, monitoring, and notification of any med error. **IV. The facility will monitor the corrective action by**	07/21/2023

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	A nurse practitioner progress note, dated 6/15/23, indicated STAT (immediate) labs were ordered due to IV antibiotic infusion. Her kidney function improved. No adverse side effects noted on exam from vancomycin administration and she did not appear in any distress. Her clinical record lacked nursing documentation, monitoring, and immediate notification to the physician of the vancomycin being infused quicker than an hour, or when the event had occurred. During an interview with LPN 23, on 7/11/23 at 1:17 p.m., she indicated Resident C's vancomycin infused faster than normal, although she was not aware of how fast it infused. She called the pharmacy and verified the settings on the IV pump, but she thought the IV pump malfunctioned. She pulled the IV pump from Resident C's room and retrieved the house IV pump for her next IV antibiotic. The nurse practitioner was made aware. During an interview with the Nurse Consultant, on 7/12/23 at 10:28 a.m., she indicated LPN 23 did not document the IV incident in Resident C's clinical record. During an interview with the Nurse Consultant, on 7/12/23 at 12:04 p.m., she indicated LPN 23 did not complete an incident report regarding the IV incident. Upon further review, the incident took place on 7/12/23. A current facility policy, titled "Adverse Consequences and Medication Errors," revised 2/14 and provided by the Nurse Consultant, on 7/12/23 at 12:04 p.m., indicated the following: "...Policy Interpretation and Implementation...13.		**implementing the following measures.** The DON, or designee, will audit residents receiving IV medications for medication errors and required documentation, monitoring and notification 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 and frequency will be adjusted as needed. **V. Plan of Correction completion date.** July 21, 2023	

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	The Attending Physician is notified promptly of any significant error or adverse consequence. a. The physician's orders are implemented, and the resident is monitored closely for 24 to 72 hours or as directed...15. The following information is documented in an incident report and in the resident's clinical record: a. Factual description of the error or adverse consequence. b. Name of physician and time notified. c. Physician's subsequent orders. d. Resident's condition for 24 to 72 hours or as directed...." This Federal tag relates to Complaint IN00411619 and IN00411859. 3.1-37(a)			