ENTERS FOR MEDICARE & MEDICAID SERVICES						OMB NO. 0938-039	
	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155511			JILDING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 06/13/2018	
	PROVIDER OR SUPPLIER	AND REHABILITATION CENTER		830 S	ADDRESS, CITY, STATE, ZIP COD 6TH ST E HAUTE, IN 47807		
	1						(V5)
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΙΤΕ	DATE
F 0000							
Bldg. 00	Licensure Survey.	55511 88720	F 00	000	F 000 Preparation and or execution this plan does not constitute of agreement by the provider of truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared or executed solely as required The facility requests the plan of correction by considered the allegation of compliance effect to the Annual State Survey conducted June 7, 2018. The facility respectfully requested when the survey conducted June 7, 2018. The facility respectfully requested the survey conducted June 7, 2018. The facility respectfully requested the survey compliance. Supporting documentation is attached.	or the s and d. of	
F 0641	accordance with 41	reflect State Findings cited in 0 IAC 16.2-3.1. upleted on June 21, 2018.					
SS=D Bldg. 00	The assessment r resident's status.	acy of Assessments. must accurately reflect the	F 00	641			07/13/2018
	failed to ensure the (MDS) assessments gain (Resident 1), a and Resident Revie	view and interview, the facility accuracy of Minimum Data Set is for weight loss and weight and Preadmission Screening w (PASRR) (Resident 17) for 2 lewed for MDS accuracy.			Preparation and or execution this plan does not constitute of agreement by the provider of truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared	or the	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Findings include:

TITLE

or executed solely as required.

(X6) DATE

Any defiency statement 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 disclodays 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.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: U7ED11 Facility ID: 000446 If continuation sheet Page 1 of 18

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	` ′		ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLETED
		155511	B. Wl	ING		06/13/2018
E OF P				STREET A	ADDRESS, CITY, STATE, ZIP COD	
NAME OF P	PROVIDER OR SUPPLIER	t .		830 S 6		
TERRE H	HAUTE NURSING A	AND REHABILITATION CENTER		TERRE	HAUTE, IN 47807	
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE
					The facility requests the plan	of
		ord was reviewed on 6/7/18 at			correction by considered the	
2:34 p.m. The resident's profile included, but was				allegation of compliance effect	tive	
		noses of dementia (a group of			to the Annual State Survey	
	-	symptoms that interfere with			conducted June 7, 2018.	
		and insomnia (persistent			The facility respectfully reques	sts a
	problems falling and	d staying asleep).			desk review to demonstrate	
					compliance. Supporting	
	A quarterly Minimu	* *			documentation is attached.	
		/1/18, indicated the resident				
	had a weight loss of 5% or more in the last month				F641	
	or loss of 10% or more in the last 6 months. The				483.20(g)	
base weight, indicated 126 pounds (lbs).				The assessment must		
					accurately reflect the resider	nt's
	A review of weights, dated October 2017 to March				status.	
	2018, indicated the	following:			How will the corrective action	n
	a. 10/9/17, 129 lbs.				be accomplished for those	
	b. 11/1/17, 131 lbs.				residents who are affected b	=
	c. 12/27/17, 132 lbs				this alleged deficient practic	
	d. 1/12/18, 127 lbs.				The MDS Coordinator correcte	
	e. 2/4/18, 125 lbs.				the error in the coding on Res	ident
	f. 3/17/18, 126 lbs.				#17 MDS dated 11/10/2017	
					How will the facility identify	
	* '	l on 5/31/18, indicated the			residents having the potentia	al
		nutritional problem or			to be affected by the same	
	-	problem related to diagnoses			deficient practice?	
		somnia. The goal, indicated the			All residents that reside within	tne
		ntain adequate nutritional			facility could potentially be	,
	status as evidence b	y maintaining weight.			affected by this alleged deficie	l l
	D wine a first first	6/12/19 -4 1.55			practice. The MDS Coordinate	
		y, on 6/13/18 at 1:55 p.m., the			conducted a 100% facility wide	
		dicated she had used			audit of MDS to ensure coding	]
		entages to compare the base			was correct.	
		recent measure to the last 30			What measures were put into	
		months of the look back			place or systematic changes	l l
	-	ulations were not correct. The			made to ensure the deficient	
		weight loss in the last month,			practice not recur?	
	_	loss in the last 6 months of the			On 6/28/18, the Social Service	
	-	he resident should not have			Designee was in-serviced by t	he
	been coded as weig	ht loss of 5% or more in the	1		Regional MDS Consultant on	

NAME OF PROVIDER OR SUPPLIER  TERRE HAUTE NURSING AND REHABILITATION CENTER  (X4) ID SUMMARY STATEMENT OF DEFICIENCIE  (X5) ID SUMMARY STATEMENT OF DEFICIENCY EXPREED BY PULL PRETIX (EACH DEFICIENCY MUST BE PRECEDED BY PULL AND SUMMARY STATEMENT OF DEFICIENCY MUST BE PRECEDED BY FULL PRETIX REGULATORY OR LSC IDENTIFYING INFORMATION TAG  I last month or loss of 10% or more in the last 6 months  Ib. Resident 1's record was reviewed on 6/7/18 at 2.34 pm. The resident's profile included, but was not limited to, diagnoses of demental (a group of thinking and social symptoms that interfere with daily functioning), and insommia (persistent problems falling and staying asleep.  A quarterly Minimum Data Set (MDS) assessment, dated 6/1/18, indicated the resident had a weight gain of 5% or more in the last 6 months. The base weight, indicated 136 pounds (lbs).  A review of weights, dated December 2017 to May 2018, indicated the following: a. 12/27/17, 132 lbs. b. 1/1/21/8, 127 lbs. c. 2/4/18, 125 lbs. d. 3/17/18, 126 lbs. e. 4/1/18, 134 lbs. f. 5/7/18, 136 lbs.  ENDRECTADDRESS, CITY, STATE, ZIP COD 830 S 8TH ST TERRE HAUTE, IN 47807  STREET ADDRESS, CITY, STATE, ZIP COD 830 S 9TH ST TERRE HAUTE, IN 47807  TERRE HAUTE, IN 47807  (X5)  PREFIX TAG  PREFIX TAG  PREFIX TAG  STREET ADDRESS, CITY, STATE, ZIP COD 830 S 9TH ST TERRE HAUTE, IN 47807  (X5)  CMPLETION DATE  A SUMMARY STATEMENT OF DEFICIENCE  ID PROVIDERS PLANCE CORRECTION (X5)  COMPLETION DATE  (X5)  PREFIX TAG
TERRE HAUTE NURSING AND REHABILITATION CENTER  TERRE HAUTE NURSING AND REHABILITATION CENTER  (X4) ID SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION TAG  last month or loss of 10% or more in the last 6 months.  Ib. Resident I's record was reviewed on 6/7/18 at 2:34 p.m. The resident's profile included, but was not limited to, diagnoses of dementia (a group of thinking and social symptoms that interfere with daily functioning), and insomnia (persistent problems falling and staying asleep.  A quarterly Minimum Data Set (MDS) assessment, dated 6/1/18, indicated the resident had a weight gain of 5% or more in the last month or gain of 10% or more in the last month or gain of 10% or more in the last month or gain of 10% or more in the last months. The base weight, indicated 136 pounds (lbs).  A review of weights, dated December 2017 to May 2018, indicated the following:  a. 12/27/17, 132 lbs. b. 1/12/18, 127 lbs. c. 2/4/18, 125 lbs. d. 3/17/18, 126 lbs. e. 4/1/18, 134 lbs. f. 5/7/18, 136 lbs.  SIMMARY STATEMAUTE, IN 47807  TERRE HAUTE, IN 47807  TERRE HAUTE, IN 47807  TERRE HAUTE, IN 47807  TERRE HAUTE, IN 47807  TO ensure completing section "A1500" of the MDS complete this section if the SSD is out of facility. MDS Coordinator was in-serviced by the Regional MDS Consultant on accuracy in coding. MDS Coordinator was in-serviced by the Regional MDS Consultant on accuracy in coding. MDS Coordinator was in-serviced by the Regional MDS Consultant on accuracy in coding. MDS Coordinator was in-serviced by the Regional MDS Consultant on accuracy in coding. MDS Coordinator was in-serviced by the Regional MDS Consultant on accuracy in coding. MDS Coordinator was in-serviced by the Regional MDS Consultant on accuracy in coding. MDS Coordinator was in-serviced by the Regional MDS Consultant on accuracy in coding. MDS Coordinator was in-serviced by the Regional MDS Consultant on accuracy in coding. MDS Coordinator was in-serviced by the Regional MDS Consultan
TERRE HAUTE NURSING AND REHABILITATION CENTER    X3   ID   SUMMARY STATEMENT OF DEFICIENCIE   REGULATORY OR LSC IDENTIFYING INFORMATION   TAG   REGULATORY OR LSC IDENTIFYING INFORMATION   TAG   REGULATORY OR LSC IDENTIFYING INFORMATION   TAG   Complete in section of the MDS. MDS Coordinator will   complete this section if the SSD   is out of facility.   MDS Coordinator was in-serviced   by the Regional MDS Consultant on accuracy in coding.   MDS Coordinator is ensuring that   SSD has the necessary Level   or   Level   Il documentation prior to   submitting the MDS.   How will the facility monitor its   corrective action?   To ensure compliance, the   Administrator/DON/MDS will   assist SSD with ensuring the   necessary Level   Indocumentation is received and   coded in the MDS correctly. QAPI   audits 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   PREFIX   TERRE HAUTE, IN 47807   TERRITAL TORS AND ACCORDINATE TO SUBJECT TO THE APPROPRIATE   COMPLETOR TO THE APPROPRIATE   CO
TERRE HAUTE NURSING AND REHABILITATION CENTER    X3   ID   SUMMARY STATEMENT OF DEFICIENCIE   REGULATORY OR LSC IDENTIFYING INFORMATION   TAG   REGULATORY OR LSC IDENTIFYING INFORMATION   TAG   REGULATORY OR LSC IDENTIFYING INFORMATION   TAG   Complete in section of the MDS. MDS Coordinator will   complete this section if the SSD   is out of facility.   MDS Coordinator was in-serviced   by the Regional MDS Consultant on accuracy in coding.   MDS Coordinator is ensuring that   SSD has the necessary Level   or   Level   Il documentation prior to   submitting the MDS.   How will the facility monitor its   corrective action?   To ensure compliance, the   Administrator/DON/MDS will   assist SSD with ensuring the   necessary Level   Indocumentation is received and   coded in the MDS correctly. QAPI   audits 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   PREFIX   TERRE HAUTE, IN 47807   TERRITAL TORS AND ACCORDINATE TO SUBJECT TO THE APPROPRIATE   COMPLETOR TO THE APPROPRIATE   CO
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had a weight gain of 5% or more in the last month or gain of 10% or more in the last 6 months. The base weight, indicated 136 pounds (lbs).  A review of weights, dated December 2017 to May 2018, indicated the following:  a. 12/27/17, 132 lbs.  b. 1/12/18, 127 lbs.  c. 2/4/18, 125 lbs.  d. 3/17/18, 126 lbs.  e. 4/1/18, 134 lbs.  f. 5/7/18, 136 lbs.  corrective action?  To ensure compliance, the Administrator/DON/MDS will assist SSD with ensuring the necessary Level I and Level II documentation is received and coded in the MDS correctly. QAPI audits 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
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2018, indicated the following:  a. 12/27/17, 132 lbs.  b. 1/12/18, 127 lbs.  c. 2/4/18, 125 lbs.  d. 3/17/18, 126 lbs.  e. 4/1/18, 134 lbs.  f. 5/7/18, 136 lbs.  documentation is received and coded in the MDS correctly. QAPI audits 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
a. 12/27/17, 132 lbs. b. 1/12/18, 127 lbs. c. 2/4/18, 125 lbs. d. 3/17/18, 126 lbs. e. 4/1/18, 134 lbs. f. 5/7/18, 136 lbs.  coded in the MDS correctly. QAPI audits 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
b. 1/12/18, 127 lbs. c. 2/4/18, 125 lbs. d. 3/17/18, 126 lbs. e. 4/1/18, 134 lbs. f. 5/7/18, 136 lbs.  audits 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
c. 2/4/18, 125 lbs. d. 3/17/18, 126 lbs. e. 4/1/18, 134 lbs. f. 5/7/18, 136 lbs.  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
d. 3/17/18, 126 lbs. e. 4/1/18, 134 lbs. f. 5/7/18, 136 lbs.  until compliance is maintained for two consecutive quarters. The results of these audits will be reviewed by the QAPI committee
e. 4/1/18, 134 lbs. f. 5/7/18, 136 lbs.  two consecutive quarters. The results of these audits will be reviewed by the QAPI committee
f. 5/7/18, 136 lbs.  results of these audits will be reviewed by the QAPI committee
reviewed by the QAPI committee
A care plan, revised on 5/31/18, indicated the monthly. If 95% compliance is not
resident may have a nutritional problem or achieved, an action place will be
potential nutritional problem related to diagnoses developed and implemented.
of dementia, and insomnia. The goal, indicated the Monthly QAPI minutes and action
resident would maintain adequate nutritional plans are submitted to regional
status as evidence by maintaining weight.  plans are submitted to regional operations staff and corporate risk
management team for review.
During an interview, on 6/13/18 at 1:55 p.m., the
Dietary Manager indicated she had used  Date Completed: July 13, 2018
pre-calculated percentages to compare the base
weight on the most recent measure to the last  F641
month and the last 6 months of the look back  483.20(g)
period, and the calculations were not correct. The The assessment must
resident was a 1.6% weight gain in the last month,  accurately reflect the resident's
and a 4.7% weight gain in the last 6 months of the status.

STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE S	URVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPLE	ETED
		155511	B. WI	NG		06/13/2	2018
			<u> </u>	CTREET A	DDDECC CITY CTATE ZID COD		
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
TEDDE	LALITE NUIDOINO A	ND DELIABILITATION CENTED		830 S 6			
TERREF	HAUTE NURSING A	AND REHABILITATION CENTER		TERRE	HAUTE, IN 47807		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROVIDED'S DI AN OF CODDECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	' E	DATE
	look back period. T	he resident should not have			How will the corrective action	n	
been coded as a weight gain of 5% or more in the				be accomplished for those			
last month, or gain of 10% or more in the last 6				residents who are affected by	v		
	months.				this alleged deficient practice		
					The Dietary Manager re-calcul		
	A copy of Section K of the Centers for Medicare				Resident #1 weights instead o		
	and Medicaid Services (CMS) Resident				using pre-loaded formulas in F		
		nent (RAI) Version 3.0			which were found to be incorre		
		ed by the MDS Coordinator			How will the facility identify		
	_	o.m. The manual indicated, "K.			residents having the potentia	al	
		onal statusK0300: Weight			to be affected by the same	41	
	lossFrom the medical record, compare the				deficient practice?		
	resident's weight in the current observation period				All residents that reside within	the	
	to his or her weight in the observation period to				facility could potentially be	uic	
		the observation period 30			affected by this alleged deficie	unt	
	-	urrent weight is less than the			practice. However, the Dietary		
		vation period 30 days ago,			Manager conducted a 100%		
	-	tage of weight loss. 3. From			facility wide audit of all weight		
	-	compare the resident's weight			calculations on the MDS.		
		vation period to his or her			What measures were put into		
		vation period 180 days ago. 4.			place or systematic changes		
		t is less than the weight in the			made to ensure the deficient		
	_	180 days ago calculate the			practice not recur?		
	_	nt loss. Coding instructions			On 6/28/18, the Dietary Manag	nor	
		sician-prescribed weight-loss			was in-serviced by the Region	-	
		lent has experienced a weight			MDS Consultant on how to	ai	
	-	in the past 30 days or 10% or					
		days, and the weight loss was			calculate weight losses/gains instead of using the pre-loader	<sub>d</sub>	
		nt to a physician's order. In				u	
	_	ent has a weight loss of 5% or			formulas in PCC. The Dietary	tor	
					Manager will continue to moni		
	_	10% or more in 180 days as a			residents for weight loss/gains		
		ian ordered diet plan or			MDS Coordinator is re-checking	-	
		s due to loss of fluid with			the Dietary Manager calculation		
		diuretics, K0300: Weight			How will the facility monitor	เเร	
	-	actionsCode 0, no or			corrective action?		
	unknownCode 2,				To ensure compliance, the DC	אנ	
		d weight-loss regimen: if the			will assist in monitoring any		
	-	enced a weight loss of 5% or			weight losses/gains in the wee		
	_	days or 10% or more in the last			NAR meeting. QAPI audits we	-	
180 days, and the weight loss was planned and				for four weeks and monthly for	rsix		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

U7ED11 Facility ID: 000446

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07/11/2018 PRINTED: FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 06/13/2018 155511 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 830 S 6TH ST TERRE HAUTE NURSING AND REHABILITATION CENTER TERRE HAUTE, IN 47807 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE pursuant to a physician's order...Code 2, yes, not months thereafter until compliance on physician-prescribed weight-loss regiment: if is maintained for two consecutive the resident has experienced a weight loss of 5% quarters. The results of these or more in the past 30 days or 10% or more in the audits will be reviewed by the last 180 days, and the weight loss was not QAPI committee monthly. If 95% planned and prescribed by a physician...K0310: compliance is not achieved, an Weight gain...From the medical record, compare action place will be developed and the resident's weight in the current observation implemented. Monthly QAPI period to his or her weight in the observation minutes and action plans are period to his or her weight in the observation submitted to regional operations period 30 days ago. 2. If the current weight is more staff and corporate risk than the weight in the observation period 30 days management team for review. ago, calculate the percentage of weight gain. 3. Date Completed: July 13, 2018 From the medical record, compare the resident's weight in the current observation period to his or her weight in the observation period 180 days ago. 4. If the current weight is more than the weight in the observation period 180 days ago calculate the percentage of weight gain. Coding instructions...Code 0, no or unknown...Code 2, yes, not on physician-prescribed weight-gain regimen...." 2. Resident 17's record was reviewed on 6/11/18 at 8:54 a.m. The resident's profile included, but was not limited to, diagnoses of psychosis (a mental disorder characterized by a disconnection from reality), and bipolar (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs). An admission Minimum Data Set (MDS) assessment, dated 11/10/17, indicated the resident did not have a PASRR. A PASRR level II mental health assessment, dated 10/23/17, indicated the resident had a PASRR completed, and a yearly resident review was required.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

U7ED11

Facility ID: 000446

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155511		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 06/13/2018	
	ROVIDER OR SUPPLIER	ND REHABILITATION CENTER	830 S 6	ADDRESS, CITY, STATE, ZIP COD STH ST HAUTE, IN 47807	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	was at risk for drug use of antipsychotic diagnoses of bipolar During an interview MDS Coordinator in PASRR level II asso 10/23/17. The admit 11/10/17, was coded included the resident A copy of Section A and Medicaid Servic Assessment Instrum Manual, was provid on 6/11/18 at 12:25 Identification Inform Screening and Resid yes: if PASRR Level the resident has a secontinue to A1510,	r, on 6/11/18 at 12:10 p.m., the indicated the resident had a essment completed on ssion MDS assessment, dated dincorrectly and should have it had a PASRR level II.			
F 0644 SS=D Bldg. 00	§483.20(e) Coordi A facility must coo the pre-admission review (PASARR) subpart C of this p practicable to avoi effort. Coordinatio	rdinate assessments with screening and resident program under Medicaid in eart to the maximum extent d duplicative testing and n includes:			
	§483.20(e)(1)Inco	rporating the			

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Event ID:

U7ED11 Facility ID: 000446

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STATEME	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	
		155511	B. W	NG		06/13	/2018
NAME OF 1	PROVIDER OR SUPPLIEF	2	1	STREET A	ADDRESS, CITY, STATE, ZIP COD	•	
				830 S 6			
TERRE I	HAUTE NURSING A	AND REHABILITATION CENTER		TERRE	E HAUTE, IN 47807		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION S from the PASARR level II	+	TAG	DEFECT.		DATE
		the PASARR evaluation					
	report into a resident's assessment, care						
	planning, and tran						
	§483.20(e)(2) Referring all level II residents and all residents with newly evident or						
	possible serious mental disorder, intellectual						
	disability, or a related condition for level II						
	resident review upon a significant change in						
	status assessmer				December of the state of the st	- <b>f</b>	07/12/2010
		view and interview, the facility	F 00	)44	Preparation and or execution		07/13/2018
	failed to ensure a resident with a newly identified mental disorder was referred to the appropriate				this plan does not constitute of		
		thority for a Level II			agreement by the provider of	uie	
		ening and Resident Review			truth of the facts alleged or conclusions set forth on the		
		on and determination for 1 of 3			statement of deficiencies. This	2	
		for PASRR (Resident 1).			plan of correction is prepared		
	233443135167167764	(			or executed solely as required		
	Findings include:				The facility requests the plan		
	_				correction by considered the		
	1. Resident 1's reco	ord was reviewed on 6/7/18 at			allegation of compliance effect	tive	
	_	lent's profile indicated the			to the Annual State Survey		
		ted to the facility on 10/9/18.			conducted June 7, 2018.		
	_	d, but was not limited to,			The facility respectfully reques	sts a	
		osis (a mental disorder			desk review to demonstrate		
		disconnection from reality)			compliance. Supporting		
		d a diagnosis of manic episode			documentation is attached		
		red with episodes of mood			E644		
	highs) added 1/9/18	m depressive lows to manic			F644   Coordination of PASARR an	d	
	inglis) added 1/9/10	J.			Assessments	u	
	A PASRR Level 1	screen outcome, dated 10/3/18,			483.20(e) Coordination		
		ent did not have a serious			How will the corrective actio	n	
		at time, and did not require			be accomplished for those		
		ess a serious mental illness and			residents who are affected b	V	
	_	in treatment needs were			this alleged deficient practic	-	
	experienced.				On June 14, 2018, the Social		
					Service Designee completed	а	
	An untitled docume	ent, dated 10/16/17, indicated			Level I on Resident #1 throug		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 06/13/2018 155511 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 830 S 6TH ST TERRE HAUTE NURSING AND REHABILITATION CENTER TERRE HAUTE, IN 47807 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE identifying information and referral history. The Ascend, Notice of PASRR Level I resident was referred for services due to problems Screen Outcome: Criteria Met for with deteriorated mental status that had been Dementia/MI Exclusion-No accompanied by some psychosis and mania. Most PASRR Level II Required. of the behavior problems seemed to be secondary Social Service Designee and to the psychosis and mania. Social Service Consultant conducted a 100% facility audit to A physician's order, dated 10/11/17, indicated ensure there were no outstanding Seroquel (antipsychotic) 50 milligrams (mg), give 1 Level 1s that need to be complete. tab by mouth (PO) two times a day (BID) for How will the facility identify psychosis. residents having the potential to be affected by the same A quarterly Minimum Data Set (MDS) deficient practice? assessment, dated 6/1/18, indicated the resident Any resident that may have a received an antipsychotic medication 7 days change in condition, new during the 7 day look back period, and had a psychiatric diagnosis and/or a new psychotic disorder diagnosis. psychiatric medication could potentially be affected by this A care plan, revised 6/8/18, indicated the resident alleged deficient practice. used a psychotropic medication related to However, the Social Service psychosis and was on a behavior management Designee conducted a facility wide program. audit to ensure that no other new Level I or Level II were required. During an interview, on 6/13/18 at 10:14 a.m., the What measures were put into Social Services Designee indicated the resident place or systematic changes did not have diagnoses of psychosis and mania made to ensure the deficient when admitted to the facility. The resident was practice not recur? started on an antipsychotic medication after On June 20, 2018, the Social admission due to the behaviors exhibited. She was Service Designee was in-serviced unsure at that time if the new diagnoses and new by Monica Marshall, Activities and antipsychotic medication would be considered a Social Services Consultant on the change in status and require an evaluation and policy titled "Level I and Level II determination of a PASRR level II. process, when to complete a new Level 1 for a significant change, During an interview, on 6/3/18 at 1:12 p.m., the change in psychotropic Social Services Designee indicated per the facility medications, and new diagnoses policy the resident should have been re-evaluated that may trigger for a new Level 2. for a PASSR level I and II process due to the new Social Service Designee will psychiatric diagnoses and new antipsychotic attend Daily QA meetings,

medication.

monthly GDR and Behavior

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/11/2018 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				SURVEY	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	
		155511	B. Wl	ING		06/13/	2018
		ND REHABILITATION CENTER		830 S 6	HAUTE, IN 47807		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'		COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	On 6/3/18 at 1:11 p. a document titled, "and indicated it was used by the facility. Level I and II proce residents with a mer are placed appropria health or rehabilitation policy of this facility. Level II process4. experience a change psychiatric diagnosis medication has been again. 5. The reside reflect the changes. a "yes" response to be requested. The faresident to the local complete the level I completed, the facility.	m., the Administrator provided Level I and level II Process," the policy currently being The policy indicated, "The ss is designed to make certain intal illness (MI) diagnosis ately and receive the mental ive therapy they need. It is the ty to participate in the Level 1/ However, should the resident is in status, for example a new is or a new psychiatric in added, the process starts int's level I must be updated to If the updated level I indicates questions 2-8, a level II must incility will need to refer the mental health agency to I. Once the new level II is ity will address the level II"			Management Meetings in order track changes in conditions, no psychotropic medications and psychiatric diagnosis.  How will the facility monitor is corrective action?  To ensure compliance, the So Service Designee is responsible monitoring any change in conditions, new psychiatric medications/diagnosis that marequire that a new Level I and Level II be completed.  The Administrator/DON will conduct random audits for any changes, based on information discussed in the behavior management meetings and Gl meetings weekly for four week 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 a implemented. Monthly QAPI minutes and action plans are submitted to the regional operations staff and corporate management for review.  Date Completed: July 13, 201	ew new its cial ile by DR is and	
F 0756 SS=D Bldg. 00	On §483.45(c) Drug R	view, Report Irregular, Act					

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Event ID:

U7ED11 Facility ID: 000446

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155511	 UILDING	NSTRUCTION  00	(X3) DATE COMPI 06/13	LETED
	PROVIDER OR SUPPLIEI	RAND REHABILITATION CENTER	830 S 6	ADDRESS, CITY, STATE, ZIP COD TH ST HAUTE, IN 47807		
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B: CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	3 RIATE	(X5) COMPLETION
TAG		r LSC IDENTIFYING INFORMATION reviewed at least once a ed pharmacist.	TAG	DEFICIENCE		DATE
	review of the resid	s review must include a dent's medical chart.				
	any irregularities t and the facility's n	e pharmacist must report to the attending physician nedical director and director ese reports must be acted				
	upon. (i) Irregularities ir to, any drug that r	nclude, but are not limited meets the criteria set forth				
	unnecessary drug (ii) Any irregulariti	of this section for an  g. es noted by the pharmacist must be documented on a				
	separate, written attending physicia director and direc	report that is sent to the an and the facility's medical tor of nursing and lists, at a ident's name, the relevant				
	drug, and the irregidentified.	gularity the pharmacist  physician must document				
	identified irregular what, if any, actio	nedical record that the rity has been reviewed and n has been taken to				
	medication, the at	e is to be no change in the ttending physician should ner rationale in the resident's				
	maintain policies monthly drug regi	e facility must develop and and procedures for the men review that include, but				
	steps in the proce pharmacist must	take when he or she ularity that requires urgent				

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PRINTED: 07/11/2018 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES			_			_	IB NO. 0938-039
STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPI	LETED
		155511	B. WI	NG		06/13	/2018
	PROVIDER OR SUPPLIER	L ND REHABILITATION CENTER	1	830 S 6	ADDRESS, CITY, STATE, ZIP COD 6TH ST E HAUTE, IN 47807		
(V4) ID	CLIMMADA	CTATEMENT OF DEFICIENCIE		ID	T		(V5)
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIADEFICIENCY)	ATE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	+	TAG			DATE
			F 07	756	Preparation and or execution		07/13/2018
		view and interview, the facility			this plan does not constitute of		
		accuracy of transcription for a			agreement by the provider of	the	
		r medication (Resident 6), a			truth of the facts alleged or		
	medication was con	tinued to be administered after			conclusions set forth on the		
	the stop date, and fa	ailed to receive a medication			statement of deficiencies. Thi	S	
	from the Pharmacy	in a timely manner (Resident 3),			plan of correction is prepared	and	
	for 2 of 12 residents	s physician's orders reviewed.			or executed solely as required	d.	
					The facility requests the plan	of	
	Findings include:				correction by considered the		
					allegation of compliance effect	ctive	
	1. Resident 6's reco	rd was reviewed on 6/11/18 at			to the Annual State Survey		
	8:42 a.m. The profi	le indicated the resident's			conducted June 7, 2018.		
	-	but were not limited to,			The facility respectfully reque	sts a	
	_	of thinking and social			desk review to demonstrate		
		fere with daily functioning),			compliance. Supporting		
		itis C (an infection caused by a			documentation is attached.		
	virus that attacks th	•			documentation to attached.		
		etes (a group of diseases that			F756		
		ugar in the blood, high blood			Drug Regimen Review, Repo	ort	
		ic pain syndrome (persistent			Irregular, Act on CFR(s):	JI L	
	pain that lasts week				_		
	pain that lasts week	s to years).			483.45(c)(1)(2)(4)(5)		
	The Medication Ad	ministration Record (MAR),			How will the corrective action	on	
		dicated the resident received			be accomplished for those		
	· ·				residents who are affected b	-	
		included, but were not limited			this alleged deficient practic		
		sium Oxide) (a mineral			All Nurses were in-serviced o	n	
		prevent and treat low			transcription accuracy and		
		ium in the blood) 400 milligram			computerized entry of Physici		
		ng by mouth two times a day			orders of medications focusin	g on	
	* *	e MAR indicated a start date of			correct medication, correct		
	1/17/18.				dosage, correct resident, corr		
					route, correct time, and to inc		
	· ·	ember 2017, indicated the			accuracy of start and stop tim	e	
		n documented as given from			regarding Resident #6		
	12/7/18 through 12/	318. The order indicated,			All Nurses were in-serviced in	1	
		blet (Magnesium Oxide). Give 1			procedures of notification to		
	mg by mouth two ti	mes a day for Supplement."			Pharmacy to obtain medication	n in	
					a timely manner and educate	d on	

A MAR, dated January 2018, indicated the

reporting form to track

	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	l í		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		ILDING	00	COMPLETED	
		155511	B. WI	NG		06/13/2018	
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
				830 S 6			
TERRE F	HAUTE NURSING A	AND REHABILITATION CENTER		TERRE	HAUTE, IN 47807		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X	5)
PREFIX	,	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	re COMPLI	
TAG		LISC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DAT	Έ
		n documented as given on all			Communication to Pharmacy		
		5/18 and 1/16/18). The order			about needed medications		
	indicated, "MagOx 400 mg tablet (Magnesium				regarding Resident #3		
	Oxide). Give 1 mg by mouth two times a day for				How will the facility identify	_	
	Supplement."				residents having the potentia		
	A MAD data d Eala	2010 : 4:			to be affected by the same		
	A MAR, dated February 2018, indicated the				deficient practice?	41	
	medication had been documented as given on all				All residents that reside within	tne	
	days (except on 2/23/18 p.m., dose through				facility could potentially be	4	
	2/25/18 a.m., dose when documented as hospitalized). The order indicated, "MagOx 400				affected by this alleged deficie	nt	
	mg tablet (Magnesium Oxide). Give 1 mg by mouth				practice. However, due to the in-serving provided by the DO	Non	
	two times a day for Supplement."				transcription accuracy,	N OII	
	two times a day for	Supplement.			computerized entry of Physicis	n'e	
	A MAR, dated March 2018, indicated the				orders of medication focusing		
		n documented as given on all			correct medication, dosage,		
		a., dose on 3/10/18 and a.m.,			resident, route, time, start/stop	,	
		he order indicated, "MagOx			time of medication, and the	<b>'</b>	
		nesium Oxide). Give 1 mg by			notification to Pharmacy to ob	ain	
		day for Supplement."			medication in a timely manner		
		any uppression			What measures were put into		
	A MAR, dated Apr	il 2018, indicated the			place or systematic changes		
	-	n documented as given on all			made to ensure the deficient		
		icated, "MagOx 400 mg tablet			practice not recur?		
	-	). Give 1 mg by mouth two			All resident's orders we	ere	
	times a day for Sup				reviewed for accuracy.		
					A copy of each order entered	n	
	A MAR, dated May	2018, indicated the			PCC will be copied.		
	medication had bee	n documented as given on all					
	days. The order ind	icated, "MagOx 400 mg tablet			MDS and DON will verify for		
	(Magnesium Oxide	). Give 1 mg by mouth two			accuracy.		
	times a day for Sup	plement."					
					Pharmacy Communication Fo	m	
		2018, indicated the			will be used by Nurses to		
		n documented as given from			document on going issues for		
	-	8. The order indicated,			specific residents medication		
		blet (Magnesium Oxide). Give 1			needs. DON will monitor this f	orm	
	mg by mouth two ti	mes a day for Supplement."			through resolution of medicati	on	
					arriving to facility.		
	A medication punch	card, with a dispensed date	1		1		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 06/13/2018 155511 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 830 S 6TH ST TERRE HAUTE NURSING AND REHABILITATION CENTER TERRE HAUTE, IN 47807 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE of 5/21/18, indicated the medication order for Magnesium-Oxide 400 mg tablet. Give 1 tablet by mouth 2 times a day for supplement. How will the facility monitor its corrective action? The Pharmacist had documented monthly To ensure compliance, the DON medication regimen reviews had been completed will monitor Physician's Orders for from December 2017 through May 2018. accuracy and computerized entry of Physician's orders of During an interview, on 6/11/18 at 9:28 a.m., the medications focusing on correct Director of Nursing (DON) indicated the MagOx medication, correct dosage, order had been documented in the computer MAR correct resident, correct route, incorrectly. The order should have been correct time, and to include documented for 1 tablet by mouth twice daily, accuracy of start and stop time. rather than 1 mg by mouth twice daily. She was As well, as notification to unable to explain why the transcribed error had Pharmacy to obtain medication in not been caught by the nurses when they a timely manner and educated on administered the medication, and why the error reporting form to track had never been reported to her by the Pharmacist Communication to Pharmacy when the monthly medication review was about needed medications. QAPI completed. audits weekly for four weeks and monthly for six months thereafter During a telephone interview, between the DON until compliance is maintained for and the Pharmacy, on 6/12/18 at 8:48 a.m., the two consecutive quarters. The Pharmacy indicated to the DON their policy was results of these audits will be to fax the facility if they identify any concerns reviewed by the QAPI committee during their medication review, or call the facility monthly. If 95% compliance is not directly if it were an emergent concern.2a. achieved, an action plan are Resident 3's record was reviewed on 6/8/18 at 3:15 submitted to regional operations p.m. The resident's profile included, but was not staff and corporate risk limited to, diagnoses of chronic pain (persistent management team for review. pain that lasts weeks to years), and edema (a condition characterized by an excess of water fluid Date completed: July 13, 2018 collecting the cavities or tissues of the body). A physician's order, dated 5/20/18, indicated Meloxicam (nonsteroidal anti-inflammatory drug) 7.5 milligrams (mg), give 1 tablet by mouth one time a day times 10 days for pain related to pain in unspecified limb, and edema.

	NT OF DEFICIENCIES  OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155511					(X3) DATE SURVEY COMPLETED 06/13/2018	
	PROVIDER OR SUPPLIEI	AND REHABILITATION CENTER		830 S 6	DDRESS, CITY, STATE, ZIP COD TH ST HAUTE, IN 47807			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE	
TAG	A review of the Me Records (MAR), da indicated the reside Meloxicam for a to was administered of June 1 to June 9, and A care plan, revised was at risk for pain and to administer in During an interview Director of Nursing clarified the Melox for 10 days, and ward days and should had 2a. Resident 3's reconstructed as a Resident 3's reconstructed as	edication Administration atted May and June 2018, and had received the medication tal of 22 days. The medication in May 20 to May 31, 2018, and and June 11, 2018.  If 3/20/18, indicated the resident related to: arthritis, knee pain, nedications as ordered.  If any on 6/12/18 at 3:20 p.m., the g (DON) indicated she had icam order wrote on 5/20/18 was as not discontinued after 10 in the second was reviewed on 6/8/18 at lent's profile included, but was moses of chronic pain the lasts weeks to years), and characterized by an excess of ing the cavities or tissues of the second in the seco		IAG			DATE	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155511		, ,	JILDING	nstruction <u>00</u>	(X3) DATE ( COMPL <b>06/13</b> /	ETED	
	PROVIDER OR SUPPLIER	ND REHABILITATION CENTER		830 S 6	DDRESS, CITY, STATE, ZIP COD TH ST HAUTE, IN 47807		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	the medication, and	resident was not allergic to had taken before. Send as e medication was ordered last					
	was at risk for pain	3/20/18, indicated the resident related to: arthritis, knee pain, edications as per ordered.					
	Director of Nursing had not received the 5/20/18. She indicat responded to an urg	(DON) indicated the facility emedication Meloxicam until ted, on 5/17/18, the facility had ent notice from the pharmacy have an allergy documented					
	document, dated 12 "Pharmacy-Related indicated it was the by the facility. The 1. A Pharmacy-relawhich the facility be the potential to cause medical intervention."	Occurrence Reporting," and policy currently being used policy indicated, "Procedure: ted occurrence is an event elieves(b) has caused, or had se, an unexpected resident n, a change in intensity of y should notify Pharmacy of					
	3.1-25(a) 3.1-25(e)(3) 3.1-25(g)(2) 3.1-25(i)						
F 0912 SS=D Bldg. 00	feet per resident ir	leasure at least 80 square					· · · · · · · · · · · · · · · · · · ·

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CTATEMEN	CTATEMENT OF DEFICIENCIES VIA DROVIDED (CLIDALIED /CLIDALIED		(X2) MULTIPLE CONSTRUCTION			ONID TO USE OF	
		X1) PROVIDER/SUPPLIER/CLIA	î ´			(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING		00	COMPLETED	
155511		155511	B. WING			06/13/2018	
NAME OF PROVIDER OR SUPPLIER				STREET A	ADDRESS, CITY, STATE, ZIP COD	•	
NAME OF P	ROVIDER OR SUPPLIER			830 S 6	STH ST		
TERRE H	HAUTE NURSING A	AND REHABILITATION CENTER	TERRE HAUTE, IN 47807				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX		(EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION			TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		DATE
	single resident roo	oms;					
	Based on observation, interview, and record		F 09	912	Preparation and or execution of		07/13/2018
					this plan does not constitute o		
	review, the facility	failed to ensure adequate			agreement by the provider of		
	square footage of li	ving space in a room occupied			truth of the facts alleged or		
		of 2 resident rooms reviewed			conclusions set forth on the		
	for square footage.				statement of deficiencies. This		
				plan of correction is			
	Findings include:				or executed solely as required		
	1 maings merade.				The facility requests the plan		
	During the initial to	our on 6/7/18 at 9:40 a m both			correction by considered the	O1	
	During the initial tour on 6/7/18 at 9:40 a.m., both room 7 and room 11 were observed occupied by 3				allegation of compliance effect	tivo	
	residents.	i were observed decupied by 5			to the Annual State Survey	uvc	
	residents.			conducted June 7, 2018.			
	Duning an interminant on (17/18 at 0.40 and 4h a			The facility respectfull		oto o	
	During an interview, on 6/7/18 at 9:49 a.m., the			desk review to demonstrate		515 a	
	Administrator indicated the facility did not have a						
	room variance waiver and, to the best of her				compliance. Supporting		
	recollection, had never had a waiver.				documentation is attached.		
	An undated document, titled, "Terre Haute				F912		
	Nursing and Rehab Square footage," inc		Bedroo		Bedrooms Measure at Least	80	
	room 7 was had a to	otal square footage of 289.50,			sq ft/Resident CFR(s): 483.90(e)		
	and room 11 had a total square footage of 2				(1)(ii)		
					How will the corrective actio	n	
	During a maintenance tour, on 6/13/18 at 8:49 a.m.,			be accomplished for those residents who are affected by this alleged deficient practice.  The Social Service Director met			
	rooms 7 and 11 were measured by the						
	Maintenance Director. The current measurement						
	of the rooms, were as follows:						
					with the residents in the room		
	a. Room 7: 19.3 feet (ft) by (x) 15.3 ft equaled			affected by the allege			
	295.29 total square feet. Square footage per				practice. One of the residents		
	resident was 98.42 square feet.				along with said resident		
	•				representative, was agreeable	e to a	
	b. Room 11: 16.2 ft x 14.3 ft equaled 231.66 total			room move. The room in			
	square feet. Square footage per resident was 77.22				now only has two residents	• • • • • • • • • • • • • • • • • • •	
	square feet.				residing in the space.		
	- T				How will the facility identify		
	During an interview, on 6/13/18 at 9:15 a.m., the				residents having the potential	al	
	Maintenance Director indicated he believed the		1	to be affected by the same			
regulations required 80 square feet of space per				deficient practice?			
regulations required 80 square feet of space per		1		actionetic practice:		I	

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/11/2018 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		COMPLETED		
	155511		B. WING 06/13/2			2018	
NAME OF PROVIDER OR SUPPLIER TERRE HAUTE NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP COD 830 S 6TH ST TERRE HAUTE, IN 47807				
(X4) ID	D SUMMARY STATEMENT OF DEFICIENCIE			ID		T	(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'		COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION			TAG DEFICIENCY)			DATE
	resident.				Any time there are more than	two	
					residents placed in this room,	they	
	During an interview, on 6/13/18 at 9:36 a.m., the Administrator indicated the facility did not have a				have the potential to be affected	· · · · · · · · · · · · · · · · · · ·	
					by the alleged deficient practice.		
		om size. They followed the			The room will continue to house		
	Federal and State regulations.		only two residents until further				
	2.1.10/13/23/13			clarification is received regarding			
	3.1-19(1)(2)(A)				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? Only two residents will reside i	n	
					the room until further clarificati		
					is received regarding the facili		
					ability to apply for the room wa	-	
					How will the facility monitor	I .	
					corrective action?		
					Residents residing in these roo	oms	
					will be monitored for potential		
					negative outcomes as a result	of	
					the room size or number of		
					residents in the room. Negativ		
					outcomes could include, but no	ot	
					limited to: privacy, personal		
					belongings, and adequate nurs	-	
					care. The social worker will us	se	
					the QIS Resident Interview		
					protocol to measure resident	tion	
					satisfaction with privacy, reten	I .	
					of personal belongings, and the adequacy of nursing care proving the control of t		
					by interviewing residents in	ideu,	
					waivered rooms monthly for si	, l	
					months and ongoing. The res	I .	
					of these interviews will be revi	I .	
					monthly by the QAPI committee		
					overseen by the administrator		
					reviewed by corporate risk		

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/11/2018 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155511	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 06/13/2018		
NAME OF PROVIDER OR SUPPLIER TERRE HAUTE NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP COD 830 S 6TH ST TERRE HAUTE, IN 47807			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					management. If a satisfaction threshold of 95% related to siz room or occupancy is not achieved an action plan will be developed to ensure resident satisfaction is achieved. Social Service Director will also conti to monitor the psychosocial well-being of the residents affe by this current alleged deficier practice.  Date Completed: July 13, 201	ze of  Il nue ected nt	

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