STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155511	A. BUILDING 00 B. WING	06/13/2018

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

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: June 7, 8, 11, 12, and 13, 2018. Facility number: 000446 Provider number: 155511 AIM number: 100288720 Census Bed Type: SNF/NF: 26 Total: 26 Census Payor Type: Medicaid: 25 Other: 1 Total: 26 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on June 21, 2018.	F 0000	**F 000** Preparation and or execution of this plan does not constitute or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and or executed solely as required. The facility requests the plan of correction by considered the allegation of compliance effective to the Annual State Survey conducted June 7, 2018. The facility respectfully requests a desk review to demonstrate compliance. Supporting documentation is attached.	
F 0641 SS=D Bldg. 00	483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. Based on record review and interview, the facility failed to ensure the accuracy of Minimum Data Set (MDS) assessments for weight loss and weight gain (Resident 1), and Preadmission Screening and Resident Review (PASRR) (Resident 17) for 2 of 12 resident's reviewed for MDS accuracy. Findings include:	F 0641	Preparation and or execution of this plan does not constitute or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and or executed solely as required.	07/13/2018

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

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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	1a. Resident 1'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 3/1/18, indicated the resident had a weight loss of 5% or more in the last month or loss of 10% or more in the last 6 months. The base weight, indicated 126 pounds (lbs). A review of weights, dated October 2017 to March 2018, indicated the following: a. 10/9/17, 129 lbs. b. 11/1/17, 131 lbs. c. 12/27/17, 132 lbs. d. 1/12/18, 127 lbs. e. 2/4/18, 125 lbs. f. 3/17/18, 126 lbs. A care plan, revised on 5/31/18, indicated the resident may have a nutritional problem or potential nutritional problem related to diagnoses of dementia, and insomnia. The goal, indicated the resident would maintain adequate nutritional status as evidence by maintaining weight. During an interview, on 6/13/18 at 1:55 p.m., the Dietary Manager indicated she had used pre-calculated percentages to compare the base weight on the most recent measure to the last 30 days and the last 6 months of the look back period, and the calculations were not correct. The resident was a 2.3% weight loss in the last month, and a 0.9% weight loss in the last 6 months of the look back period. The resident should not have been coded as weight loss of 5% or more in the		The facility requests the plan of correction by considered the allegation of compliance effective to the Annual State Survey conducted June 7, 2018. The facility respectfully requests a desk review to demonstrate compliance. Supporting documentation is attached. **F641** **483.20(g)** **The assessment must accurately reflect the resident's status.** **How will the corrective action be accomplished for those residents who are affected by this alleged deficient practice.** The MDS Coordinator corrected the error in the coding on Resident #17 MDS dated 11/10/2017 **How will the facility identify residents having the potential to be affected by the same deficient practice?** All residents that reside within the facility could potentially be affected by this alleged deficient practice. The MDS Coordinator conducted a 100% facility wide audit of MDS to ensure coding was correct. **What measures were put into place or systematic changes made to ensure the deficient practice not recur?** On 6/28/18, the Social Service Designee was in-serviced by the Regional MDS Consultant on	

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	last month or loss of 10% or more in the last 6 months. . 1b. Resident 1'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 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. A care plan, revised on 5/31/18, indicated the resident may have a nutritional problem or potential nutritional problem related to diagnoses of dementia, and insomnia. The goal, indicated the resident would maintain adequate nutritional status as evidence by maintaining weight. During an interview, on 6/13/18 at 1:55 p.m., the Dietary Manager indicated she had used pre-calculated percentages to compare the base weight on the most recent measure to the last month and the last 6 months of the look back period, and the calculations were not correct. The resident was a 1.6% weight gain in the last month, and a 4.7% weight gain in the last 6 months of the		completing section “A1500” 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 I or Level II 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 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 monthly. If 95% compliance is not achieved, an action place will be developed and implemented. Monthly QAPI minutes and action plans are submitted to regional operations staff and corporate risk management team for review. **Date Completed: July 13, 2018** **F641** **483.20(g)** **The assessment must accurately reflect the resident’s status.**	

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	look back period. The resident should not have been coded as a weight gain of 5% or more in the last month, or gain of 10% or more in the last 6 months. A copy of Section K of the Centers for Medicare and Medicaid Services (CMS) Resident Assessment Instrument (RAI) Version 3.0 Manual, was provided by the MDS Coordinator on 6/13/18 at 2:30 p.m. The manual indicated, "...K. Swallowing/Nutritional status...K0300: Weight loss...From the medical record, compare the resident's weight in the current observation period to his or her weight in the observation period to his or her weight in the observation period 30 days ago. 2. If the current weight is less than the weight in the observation period 30 days ago, calculate the percentage of weight loss. 3. 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 less than the weight in the observation period 180 days ago calculate the percentage of weight loss. Coding instructions... Code 1, yes on physician-prescribed weight-loss regimen: if the resident has experienced a weight loss of 5% or more in the past 30 days or 10% or more in the last 180 days, and the weight loss was planned and pursuant to a physician's order. In cases where a resident has a weight loss of 5% or more in 30 days or 10% or more in 180 days as a result of any physician ordered diet plan or expected weight loss due to loss of fluid with physician orders for diuretics, K0300: Weight Loss...Coding instructions...Code 0, no or unknown...Code 2, yes, not on physician-prescribed weight-loss regimen: if the resident has experienced a weight loss of 5% or more in the past 30 days or 10% or more in the last 180 days, and the weight loss was planned and		**How will the corrective action be accomplished for those residents who are affected by this alleged deficient practice.** The Dietary Manager re-calculated Resident #1 weights instead of using pre-loaded formulas in PCC, which were found to be incorrect. **How will the facility identify residents having the potential to be affected by the same deficient practice?** All residents that reside within the facility could potentially be affected by this alleged deficient practice. However, the Dietary Manager conducted a 100% facility wide audit of all weight calculations on the MDS. **What measures were put into place or systematic changes made to ensure the deficient practice not recur?** On 6/28/18, the Dietary Manager was in-serviced by the Regional MDS Consultant on how to calculate weight losses/gains instead of using the pre-loaded formulas in PCC. The Dietary Manager will continue to monitor residents for weight loss/gains. MDS Coordinator is re-checking the Dietary Manager calculations. **How will the facility monitor its corrective action?** To ensure compliance, the DON will assist in monitoring any weight losses/gains in the weekly NAR meeting. QAPI audits weekly for four weeks and monthly for six	

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	pursuant to a physician's order...Code 2, yes, not on physician-prescribed weight-loss regiment: if the resident has experienced a weight loss of 5% or more in the past 30 days or 10% or more in the last 180 days, and the weight loss was not planned and prescribed by a physician...K0310: Weight gain...From the medical record, compare the resident's weight in the current observation period to his or her weight in the observation period to his or her weight in the observation period 30 days ago. 2. If the current weight is more than the weight in the observation period 30 days ago, calculate the percentage of weight gain. 3. 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.		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 place will be developed and implemented. Monthly QAPI minutes and action plans are submitted to regional operations staff and corporate risk management team for review. **Date Completed: July 13, 2018**	

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	A care plan, revised 5/4/18, indicated the resident was at risk for drug related side effects from the use of antipsychotic medications for the diagnoses of bipolar and psychosis. During an interview, on 6/11/18 at 12:10 p.m., the MDS Coordinator indicated the resident had a PASRR level II assessment completed on 10/23/17. The admission MDS assessment, dated 11/10/17, was coded incorrectly and should have included the resident had a PASRR level II. A copy of Section A of the Centers for Medicare and Medicaid Services (CMS) Resident Assessment Instrument (RAI) Version 3.0 Manual, was provided by the MDS Coordinator on 6/11/18 at 12:25 p.m. The manual indicated, "A. Identification Information...A1500: Preadmission Screening and Resident Review (PASRR)...Code 1, yes: if PASRR Level II screening determined that the resident has a serious mental illness... and continue to A1510, Level II Preadmission Screening and Resident Review (PASRR) conditions...." 3.1-31(c)(1) 3.1-31(c)(3) 3.1-31(c)(5)			
F 0644 SS=D Bldg. 00	483.20(e)(1)(2) Coordination of PASARR and Assessments §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the			

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	recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §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 assessment. Based on record review and interview, the facility failed to ensure a resident with a newly identified mental disorder was referred to the appropriate state-designated authority for a Level II Preadmission Screening and Resident Review (PASRR) evaluation and determination for 1 of 3 residents reviewed for PASRR (Resident 1). Findings include: 1. Resident 1's record was reviewed on 6/7/18 at 2:34 p.m. The resident's profile indicated the resident was admitted to the facility on 10/9/18. The profile included, but was not limited to, diagnosis of psychosis (a mental disorder characterized by a disconnection from reality) added 10/11/17, and a diagnosis of manic episode (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs) added 1/9/18. A PASRR Level 1 screen outcome, dated 10/3/18, indicated the resident did not have a serious mental illness at that time, and did not require more screening unless a serious mental illness and significant change in treatment needs were experienced. An untitled document, dated 10/16/17, indicated	F 0644	Preparation and or execution of this plan does not constitute or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and or executed solely as required. The facility requests the plan of correction by considered the allegation of compliance effective to the Annual State Survey conducted June 7, 2018. The facility respectfully requests a desk review to demonstrate compliance. Supporting documentation is attached **F644** **Coordination of PASARR and Assessments** **483.20(e) Coordination** **How will the corrective action be accomplished for those residents who are affected by this alleged deficient practice.** On June 14, 2018, the Social Service Designee completed a Level I on Resident #1 through	07/13/2018

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	identifying information and referral history. The resident was referred for services due to problems with deteriorated mental status that had been accompanied by some psychosis and mania. Most of the behavior problems seemed to be secondary to the psychosis and mania. A physician's order, dated 10/11/17, indicated Seroquel (antipsychotic) 50 milligrams (mg), give 1 tab by mouth (PO) two times a day (BID) for psychosis. A quarterly Minimum Data Set (MDS) assessment, dated 6/1/18, indicated the resident received an antipsychotic medication 7 days during the 7 day look back period, and had a psychotic disorder diagnosis. A care plan, revised 6/8/18, indicated the resident used a psychotropic medication related to psychosis and was on a behavior management program. During an interview, on 6/13/18 at 10:14 a.m., the Social Services Designee indicated the resident did not have diagnoses of psychosis and mania when admitted to the facility. The resident was started on an antipsychotic medication after admission due to the behaviors exhibited. She was unsure at that time if the new diagnoses and new antipsychotic medication would be considered a change in status and require an evaluation and determination of a PASRR level II. During an interview, on 6/3/18 at 1:12 p.m., the Social Services Designee indicated per the facility policy the resident should have been re-evaluated for a PASSR level I and II process due to the new psychiatric diagnoses and new antipsychotic medication.		Ascend. Notice of PASRR Level I Screen Outcome: Criteria Met for Dementia/MI Exclusion-No PASRR Level II Required. Social Service Designee and Social Service Consultant conducted a 100% facility audit to ensure there were no outstanding Level 1s that need to be complete. **How will the facility identify residents having the potential to be affected by the same deficient practice?** Any resident that may have a change in condition, new psychiatric diagnosis and/or a new psychiatric medication could potentially be affected by this alleged deficient practice. However, the Social Service Designee conducted a facility wide audit to ensure that no other new Level I or Level II were required. **What measures were put into place or systematic changes made to ensure the deficient practice not recur?** On June 20, 2018, the Social Service Designee was in-serviced by Monica Marshall, Activities and Social Services Consultant on the policy titled “Level I and Level II process, when to complete a new Level 1 for a significant change, change in psychotropic medications, and new diagnoses that may trigger for a new Level 2. Social Service Designee will attend Daily QA meetings, monthly GDR and Behavior	

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	On 6/3/18 at 1:11 p.m., the Administrator provided a document titled, "Level I and level II Process," and indicated it was the policy currently being used by the facility. The policy indicated, "...The Level I and II process is designed to make certain residents with a mental illness (MI)... diagnosis are placed appropriately and receive the mental health or rehabilitative therapy they need. It is the policy of this facility to participate in the Level 1/ Level II process...4. However, should the resident experience a change in status, for example a new psychiatric diagnosis or a new psychiatric medication has been added, the process starts again. 5. The resident's level I must be updated to reflect the changes. If the updated level I indicates a "yes" response to questions 2-8, a level II must be requested. The facility will need to refer the resident to the local mental health agency to complete the level II. Once the new level II is completed, the facility will address the level II...."		Management Meetings in order to track changes in conditions, new psychotropic medications and new psychiatric diagnosis. **How will the facility monitor its corrective action?** To ensure compliance, the Social Service Designee is responsible monitoring any change in conditions, new psychiatric medications/diagnosis that may require 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 GDR meetings weekly for four weeks and monthly for six months thereafter until compliance is maintained for two consecutive quarters. The results of these audits will be reviewed by the QAPI committee monthly. If 95% compliance is not achieved, an action plan will be developed and implemented. Monthly QAPI minutes and action plans are submitted to the regional operations staff and corporate risk management for review. **Date Completed: July 13, 2018**	
F 0756 SS=D Bldg. 00	483.45(c)(1)(2)(4)(5) Drug Regimen Review, Report Irregular, Act On §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each			

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	resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident.			

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	Based on record review and interview, the facility failed to ensure the accuracy of transcription for a physician's order for medication (Resident 6), a medication was continued to be administered after the stop date, and failed to receive a medication from the Pharmacy in a timely manner (Resident 3), for 2 of 12 residents physician's orders reviewed. Findings include: 1. Resident 6's record was reviewed on 6/11/18 at 8:42 a.m. The profile indicated the resident's diagnoses included, but were not limited to, dementia (a group of thinking and social symptoms that interfere with daily functioning), chronic viral Hepatitis C (an infection caused by a virus that attacks the liver and leads to inflammation), diabetes (a group of diseases that result in too much sugar in the blood, high blood glucose), and chronic pain syndrome (persistent pain that lasts weeks to years). The Medication Administration Record (MAR), dated June 2018, indicated the resident received medications which included, but were not limited to, MagOx (Magnesium Oxide) (a mineral supplement used to prevent and treat low amounts of magnesium in the blood) 400 milligram (mg) tablet, give 1 mg by mouth two times a day for supplement. The MAR indicated a start date of 1/17/18. A MAR, dated December 2017, indicated the medication had been documented as given from 12/7/18 through 12/318. The order indicated, "MagOx 400 mg tablet (Magnesium Oxide). Give 1 mg by mouth two times a day for Supplement." A MAR, dated January 2018, indicated the	F 0756	Preparation and or execution of this plan does not constitute or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and or executed solely as required. The facility requests the plan of correction by considered the allegation of compliance effective to the Annual State Survey conducted June 7, 2018. The facility respectfully requests a desk review to demonstrate compliance. Supporting documentation is attached. **F756** **Drug Regimen Review, Report Irregular, Act on CFR(s): 483.45(c)(1)(2)(4)(5)** **How will the corrective action be accomplished for those residents who are affected by this alleged deficient practice.** All Nurses were in-serviced on transcription accuracy and computerized entry of Physician's orders of medications focusing on correct medication, correct dosage, correct resident, correct route, correct time, and to include accuracy of start and stop time regarding Resident #6 All Nurses were in-serviced in procedures of notification to Pharmacy to obtain medication in a timely manner and educated on reporting form to track	07/13/2018

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	155511	A. BUILDING 00 B. WING	06/13/2018

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	medication had been documented as given on all days (except on 1/15/18 and 1/16/18). The order indicated, "MagOx 400 mg tablet (Magnesium Oxide). Give 1 mg by mouth two times a day for Supplement." A MAR, dated February 2018, indicated the medication had been documented as given on all days (except on 2/23/18 p.m., dose through 2/25/18 a.m., dose when documented as hospitalized). The order indicated, "MagOx 400 mg tablet (Magnesium Oxide). Give 1 mg by mouth two times a day for Supplement." A MAR, dated March 2018, indicated the medication had been documented as given on all days (except on p.m., dose on 3/10/18 and a.m., dose on 3/11/18). The order indicated, "MagOx 400 mg tablet (Magnesium Oxide). Give 1 mg by mouth two times a day for Supplement." A MAR, dated April 2018, indicated the medication had been documented as given on all days. The order indicated, "MagOx 400 mg tablet (Magnesium Oxide). Give 1 mg by mouth two times a day for Supplement." A MAR, dated May 2018, indicated the medication had been documented as given on all days. The order indicated, "MagOx 400 mg tablet (Magnesium Oxide). Give 1 mg by mouth two times a day for Supplement." A MAR, dated June 2018, indicated the medication had been documented as given from 6/18 through 6/11/18. The order indicated, "MagOx 400 mg tablet (Magnesium Oxide). Give 1 mg by mouth two times a day for Supplement." A medication punch card, with a dispensed date		Communication to Pharmacy about needed medications regarding Resident #3 **How will the facility identify residents having the potential to be affected by the same deficient practice?** All residents that reside within the facility could potentially be affected by this alleged deficient practice. However, due to the in-serving provided by the DON on transcription accuracy, computerized entry of Physician's orders of medication focusing on correct medication, dosage, resident, route, time, start/stop time of medication, and the notification to Pharmacy to obtain medication in a timely manner. **What measures were put into place or systematic changes made to ensure the deficient practice not recur?** All resident's orders were reviewed for accuracy. A copy of each order entered in PCC will be copied. MDS and DON will verify for accuracy. Pharmacy Communication Form will be used by Nurses to document on going issues for specific residents medication needs. DON will monitor this form through resolution of medication arriving to facility.	

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	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. The Pharmacist had documented monthly medication regimen reviews had been completed from December 2017 through May 2018. During an interview, on 6/11/18 at 9:28 a.m., the Director of Nursing (DON) indicated the MagOx order had been documented in the computer MAR incorrectly. The order should have been documented for 1 tablet by mouth twice daily, rather than 1 mg by mouth twice daily. She was unable to explain why the transcribed error had not been caught by the nurses when they administered the medication, and why the error had never been reported to her by the Pharmacist when the monthly medication review was completed. During a telephone interview, between the DON and the Pharmacy, on 6/12/18 at 8:48 a.m., the Pharmacy indicated to the DON their policy was to fax the facility if they identify any concerns during their medication review, or call the facility directly if it were an emergent concern.2a. Resident 3's record was reviewed on 6/8/18 at 3:15 p.m. The resident's profile included, but was not limited to, diagnoses of chronic pain (persistent pain that lasts weeks to years), and edema (a condition characterized by an excess of water fluid 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.		**How will the facility monitor its corrective action?** To ensure compliance, the DON will monitor Physician's Orders for accuracy and computerized entry of Physician's orders of medications focusing on correct medication, correct dosage, correct resident, correct route, correct time, and to include accuracy of start and stop time. As well, as notification to Pharmacy to obtain medication in a timely manner and educated on reporting form to track Communication to Pharmacy about needed medications. 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 monthly. If 95% compliance is not achieved, an action plan are submitted to regional operations staff and corporate risk management team for review. **Date completed: July 13, 2018**	

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	A review of the Medication Administration Records (MAR), dated May and June 2018, indicated the resident had received the medication Meloxicam for a total of 22 days. The medication was administered on May 20 to May 31, 2018, and June 1 to June 9, and June 11, 2018. A care plan, revised 3/20/18, indicated the resident was at risk for pain related to: arthritis, knee pain, and to administer medications as ordered. During an interview, on 6/12/18 at 3:20 p.m., the Director of Nursing (DON) indicated she had clarified the Meloxicam order wrote on 5/20/18 was for 10 days, and was not discontinued after 10 days and should have been. 2a. Resident 3's record was reviewed on 6/8/18 at 3:15 p.m. The resident's profile included, but was not limited to, diagnoses of chronic pain (persistent pain that lasts weeks to years), and edema (a condition characterized by an excess of water fluid collecting the cavities or tissues of the body). A physician's order, dated 5/12/18 and discontinued 5/19/18, indicated Meloxicam (nonsteroidal anti-inflammatory drug) 7.5 milligrams (mg), give 1 tablet by mouth in the morning for swelling in left leg. A Medication Administration Record (MAR), dated May 2018, indicated that the resident did not receive Meloxicam medication from 5/15 to 5/19/18, and was pending arrival from pharmacy. A document, titled, "Urgent! Your order cannot be processed," dated 5/17/18, indicated the resident was allergic to Meloxicam, and the order would not be processed without clarification. A			

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	response noted the resident was not allergic to the medication, and had taken before. Send as soon as possible, the medication was ordered last week. A care plan, revised 3/20/18, indicated the resident was at risk for pain related to: arthritis, knee pain, and to administer medications as per ordered. During an interview, on 6/12/18 at 3:20 p.m., the Director of Nursing (DON) indicated the facility had not received the medication Meloxicam until 5/20/18. She indicated, on 5/17/18, the facility had responded to an urgent notice from the pharmacy that resident did not have an allergy documented to the medication. On 6/12/18 at 8:52 a.m., the DON provided a document, dated 12/18/06, titled, "Pharmacy-Related Occurrence Reporting," and indicated it was the policy currently being used by the facility. The policy indicated, "...Procedure: 1. A Pharmacy-related occurrence is an event which the facility believes...(b) has caused, or had the potential to cause, an unexpected resident medical intervention, a change in intensity of care...2. The facility should notify Pharmacy of any possible dispensing occurrence...." 3.1-25(a) 3.1-25(e)(3) 3.1-25(g)(2) 3.1-25(i)			
F 0912 SS=D Bldg. 00	483.90(e)(1)(ii) Bedrooms Measure at Least 80 Sq Ft/Resident §483.90(e)(1)(ii) Measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in			

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	single resident rooms; Based on observation, interview, and record review, the facility failed to ensure adequate square footage of living space in a room occupied by 3 residents, for 1 of 2 resident rooms reviewed for square footage. Findings include: During the initial tour on 6/7/18 at 9:40 a.m., both room 7 and room 11 were observed occupied by 3 residents. During an interview, on 6/7/18 at 9:49 a.m., the Administrator indicated the facility did not have a room variance waiver and, to the best of her recollection, had never had a waiver. An undated document, titled, "Terre Haute Nursing and Rehab Square footage," indicated room 7 was had a total square footage of 289.50, and room 11 had a total square footage of 231.66. During a maintenance tour, on 6/13/18 at 8:49 a.m., rooms 7 and 11 were measured by the Maintenance Director. The current measurement of the rooms, were as follows: a. Room 7: 19.3 feet (ft) by (x) 15.3 ft equaled 295.29 total square feet. Square footage per resident was 98.42 square feet. b. Room 11: 16.2 ft x 14.3 ft equaled 231.66 total square feet. Square footage per resident was 77.22 square feet. During an interview, on 6/13/18 at 9:15 a.m., the Maintenance Director indicated he believed the regulations required 80 square feet of space per	F 0912	Preparation and or execution of this plan does not constitute or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and or executed solely as required. The facility requests the plan of correction by considered the allegation of compliance effective to the Annual State Survey conducted June 7, 2018. The facility respectfully requests a desk review to demonstrate compliance. Supporting documentation is attached. **F912** **Bedrooms Measure at Least 80 sq ft/Resident CFR(s): 483.90(e)(1)(ii)** **How will the corrective action be accomplished for those residents who are affected by this alleged deficient practice.** The Social Service Director met with the residents in the room affected by the alleged deficient practice. One of the residents, along with said resident representative, was agreeable to a room move. The room in question now only has two residents residing in the space. **How will the facility identify residents having the potential to be affected by the same deficient practice?**	07/13/2018

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	resident. During an interview, on 6/13/18 at 9:36 a.m., the Administrator indicated the facility did not have a policy related to room size. They followed the Federal and State regulations. 3.1-19(l)(2)(A)		Any time there are more than two residents placed in this room, they have the potential to be affected by the alleged deficient practice. The room will continue to house only two residents until further clarification is received regarding the facility's ability to apply for the room waiver. **What measures were put into place or systematic changes made to ensure the deficient practice not recur?** Only two residents will reside in the room until further clarification is received regarding the facility's ability to apply for the room waiver. **How will the facility monitor its corrective action?** Residents residing in these rooms will be monitored for potential negative outcomes as a result of the room size or number of residents in the room. Negative outcomes could include, but not limited to: privacy, personal belongings, and adequate nursing care. The social worker will use the QIS Resident Interview protocol to measure resident satisfaction with privacy, retention of personal belongings, and the adequacy of nursing care provided, by interviewing residents in waivered rooms monthly for six months and ongoing. The results of these interviews will be reviewed monthly by the QAPI committee overseen by the administrator and reviewed by corporate risk	

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			management. If a satisfaction threshold of 95% related to size of room or occupancy is not achieved an action plan will be developed to ensure resident satisfaction is achieved. Social Service Director will also continue to monitor the psychosocial well-being of the residents affected by this current alleged deficient practice. **Date Completed: July 13, 2018**	