STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155444	A. BUILDING 00 B. WING	10/28/2016

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NORWOOD HEALTH AND REHABILITATION CENTER	3720 N NORWOOD RD HUNTINGTON, IN 46750

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: October 24, 25, 26, 27, and 28, 2016. Facility number: 000463 Provider number: 155444 AIM number: 100290910 Census bed type: SNF/NF: 40 Total: 40 Census payor type: Medicare: 2 Medicaid: 30 Other: 8 Total: 40 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1. Quality Review completed by 09674 on November 7, 2016.	F 0000	This Plan of Correction is Norwood Health and Rehabilitation Center's credible allegation of compliance. Preparation and execution of this plan of correction does not constitute admission or agreement of Norwood Health and Rehabilitation Center to the facts alleged or the conclusions set forth in the statement of deficiencies. This Plan of Correction is prepared and executed solely because it is required by the provisions of federal and state law.	
F 0157	483.10(b)(11)			

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

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SS=D Bldg. 00	NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. Based on record review and interview, the facility failed to notify the physician of a change in condition for 1 of 5 residents reviewed for unnecessary medications (Resident #50).	F 0157	F157 Notification of Changes Resident #50 Nurse Practitioner notified by DON/Designee on 10/27/2016 of resident #50 blood pressure readings. Resident #50 blood pressure evaluation times changed after discussion with Nurse	11/27/2016

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	Findings include: The clinical record for Resident #50 was reviewed on 10/26/16 at 9:51 a.m. The resident had diagnoses which included, but were not limited to, cerebrovascular disease, cerebral infarction due to unspecified occlusion or stenosis of unspecified cerebral artery, edema and hypertension. The review of the resident's "Weights and Vitals Summary" indicated the following blood pressures: a. On 10/22/16 at 7:57 a.m., it was 163/99 mmHg [millimeter of mercury]. b. On 10/20/16 at 7:40 a.m., it was 173/107 mmHg. c. On 10/19/16 at 7:28 a.m., it was 159/101 mmHg. d. On 10/5/16 at 7:44 a.m., it was 168/106 mmHg. e. On 10/2/16 at 8:13 a.m., it was 165/105 mmHg. f. On 9/26/16 at 7:48 a.m., it was 162/107 mmHg. g. On 9/18/16 at 7:49 a.m., it was 171/101 mmHg. h. On 9/7/16 at 8:03 a.m., it was 174/84 mmHg. i. On 9/4/16 at 6:08 p.m., it was 182/78 mmHg. j. On 9/4/16 at 7:51 a.m., it was 186/82		Practitioner to ensure a more accurate blood pressure measurement. Administration time changes made to resident #50's blood pressure medications. Residents prescribed blood pressure medications have the potential to be affected by the same deficient practice. Residents that are prescribed blood pressure medications will be audited for blood pressure readings outside of parameters. MD or Nurse Practitioner will be notified of audit findings and any changes in medication regimen will be initiated. Residents that are prescribed blood pressure medications will be assessed prior to giving blood pressure medications. If systolic blood pressure is greater than indicated parameter, medication will be given per Physician's order and nurse will reassess blood pressure reading in approximately 30 minutes. MD or Nurse Practitioner will then be notified if BP reading continues to be above parameter. Nurses to be educated on expectations of Physician Notification of Changes on 11/22/16. DON or designee will run vital sign summary report for blood pressure readings and report will be monitored during morning clinical meeting Monday through Friday to identify any blood pressures that are greater than physician specified parameter and follow up will be	

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	mmHg. The review of the nurses' notes on 10/20/16 at 2:30 p.m.., indicated "Resident c/o [complain of] feeling tired today. Did vomit x [times] 1 before breakfast, but states she feels better now...." The clinical record lacked documentation of physician notification regarding the resident's elevated blood pressures. A current care plan with the problem "The resident has coronary artery disease (CAD) r/t [related to] Hypertension" indicated "Monitor blood pressure. Notify physician of any abnormal reading...." During an interview with the Nurse Consultant on 10/27/16 at 10:08 a.m., she indicated there were blood pressures definitely out of the resident's normal baseline and the staff should have reassessed the elevated blood pressures and notified the physician if the blood pressure level remained outside of the resident's normal baseline. During an interview with the Nurse Practitioner on 10/27/16 at 11:06 a.m., she indicated the resident's baseline blood pressure range was 140's systolic and 80's		completed to ensure MD or Nurse Practitioner notification was completed. This will be completed 5 times a week for 4 weeks, then weekly for 4 weeks, then monthly for 4 months to ensure substantial compliance achieved. DON or designee will report findings to Quality Assurance Committee monthly x 6 months for review and QA will be discontinued when continued substantial compliance achieved. All systemic changes will be completed by 11/27/2016.	

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	diastolic. The Nurse Practitioner indicated the nurse should have reassessed the blood pressure if it was greater than 165 systolic and if it was still over the 165 systolic than the physician or nurse practitioner should have been notified. During an interview with the Assistant Director of Nursing on 10/27/16 at 11:15 a.m., she indicated the nurse was the one who would assess the resident's blood pressure. A current facility policy titled "COVENANT CARE OPERATING STANDARD MANAGING CHANGE OF CONDITION" dated 10/2011, provided by the Nurse Consultant on 10/27/16 at 10:56 a.m., indicated the following: "Objective: To appropriately assess, document, and communicate changes of condition (COC) to the primary care provider. To provide treatment and services to address changes in accordance with resident needs and existing Advance Directives. ...If the change in condition does not			

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	appear life-threatening, the following steps may be followed: ...2. Notify the physician... of assessment findings... ...4. Document assessment findings and communications...." No further information was provided by exit on 10/28/16. 3.5-1(a)(2)			
F 0164 SS=D Bldg. 00	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.			

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	The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. Based on observation and record review, the facility failed to ensure visual privacy was provided for 1 of 2 residents observed receiving dressing changes for pressure ulcers. (Resident #13) Finding includes: During the observation of a pressure ulcer, conducted on 10/27/16 at 9:08 a.m., LPN #30 was observed to gather her supplies and enter Resident #13's room. She then placed her supplies on an over bed table and washed her hands. She then exposed the resident's buttocks by pulling down his shorts. She then removed the old dressings from his lower coccyx area without pulling the privacy curtain or shutting his room blinds. The resident's buttocks were facing towards the big picture windows. The windows provided an unobstructed view to the employee parking lot. LPN #30 completed the whole dressing change without providing any visual privacy from the window side of the resident's room.	F 0164	F164- Personal Privacy Resident #13 will have either room divider curtain pulled (his wife is his roommate) or blinds closed in window to employee parking lot prior to completing dressing changes. Nurse #30 was educated 10/27/2016 regarding providing privacy for residents during dressing changes. Residents receiving dressing changes have the potential to be affected by the same deficient practice. Room divider curtain and/or window blind will be closed during any dressing changes for all residents. Nurses will be educated on privacy practices during dressing changes or treatments on 11/22/2016. DON or designee to complete dressing change observation 1 time weekly for 4 weeks,, then monthly for 6 months thereafter to ensure the deficient practice does not recur. Quality Assurance results will be forwarded by DON/Designee to Quality Assurance Committee for review and QA will be discontinued when continued substantial compliance achieved. All training and changes will be complete by 11/27/2016.	11/27/2016

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	The facility policy and procedure, titled, "Dressing Change, Clean", undated and provided by the Assistant Director of Nursing (ADON) on 10/28/16 at 8:42 a.m., did not include any measures to ensure privacy was provided. 3.1-3(o)			
F 0241 SS=E Bldg. 00	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Based on observation, interview, and record review, the facility failed to ensure residents did not experience long wait times and were offered timely assistance with their meals for 3 of 21 residents receiving their meals in the main dining room (Residents #1, #28, and #11). Findings include: During a dining observation in the main dining room, beginning on 10/24/16 at 11:55 a.m., the following was observed:	F 0241	F 241 Dignity Residents requiring assistance during mealtimes will be served their meal when staff is present and able to assist them. Drinks provided will be uncovered at place setting. Meals will be prepared by making silverware accessible to the resident. Staff members will be seated when assisting residents with their food. Food and drinks will be cleansed off resident faces during meal service using their napkin. Residents requiring assistance as identified on most recent MDS have the potential to be affected by the same deficient practice and also will	11/27/2016

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	At 11:58 a.m., Residents #28 and #11's meal trays were placed in front of them. No assistance was given to begin eating their meals. At 12:05 p.m., CNA #50 began assisting Resident #28 with her meal. The CNA moved her wheelchair without warning her, to make room for Resident #1, who was being propelled by LPN #51. CNA #50 indicated there was not enough room and asked the SSD to seat Resident #2 at another table. The LPN propelled her to a table and seated her by herself. She then placed the resident's covered drinks in front of her and walked away from the table. Resident #11 remained seated at the table, with her head down and eyes closed. Her tray was untouched in front of her. CNA #50 stood next to Resident #28, who was staring forward, and asked her to pick up the spoon and take a bite. When she did not pick up the spoon, she sat next to her and offered the resident a bite of food. At 12:10 p.m., the SSD served Resident #1's meal to her, indicating she would be right back. The covered drinks remained on the table above the food and the utensils remained in the napkin.		be assisted appropriately during mealtimes. Staff to be educated on dignity with dining and proper assistance techniques on 11/22/16. Facility management serving as dining manager will also be educated on proper dining room procedures to better monitor the staff serving the residents prior to 11/27/2016.. Facility to assign dining manager and/or a nurse who will serve as dining room manager in the absence of facility management to monitor and assist with dining service as needed. Dining manager will audit the dining service in the dining room to ensure residents are being fed when food and drinks presented, staff members being seated while feeding, food and drinks being cleansed off of resident's faces during meal service, meals prepared and silverware made accessible to residents. This will be done at 2 out of 3 meals daily 5 times per week for 4 weeks, then weekly for 4 weeks and monthly for 4 months to ensure continued compliance. DON or designee will report findings of dining room observations to Quality Assurance Committee monthly for 6 months for review and QA will be discontinued when substantial compliance achieved. All corrections will be completed by 11/27/2016.	

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	At 12:12 p.m., CNA #50 again asked Resident #28 to pick up her spoon and take a bite, as she walked away from the table. The resident continued to stare forward. Resident #1 remained seated alone at a nearby table, with her untouched food in front of her and her drinks covered. CNA #50 then placed a clothing protector on the resident and sat down next to her and began assisting her with her meal. CNA #52 sat down next to Resident #11. CNA #52 indicated loudly to Resident #28 to eat, from across the table where she was seated next to Resident #11, whose Broda chair (a high-backed reclining wheelchair) she moved without warning. She offered her a drink from an adaptive cup, indicating she wasn't sure what it was. She raised the cup to her nose, indicated it smelled like a milkshake, and offered her a drink of it. She continued assisting her with her meal, while food and liquid dripped from the left side of her mouth, onto her clothing protector. She then mixed the resident's pureed cake into the adaptive cup containing the remaining milkshake, and offered it to her to drink. The CNA did not wipe her mouth during the meal. At 12:23 p.m., CNA #50 assisted Resident #1 from the dining room.			

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At 12:30 p.m., CNA #52 sat next to Resident #28 and asked if she was hungry. She indicated she was, and began accepting bites of food offered from the CNA. She then accepted a small cup of chocolate milk that the CNA placed in her hand and drank it in three swallows. She then accepted a small cup of fruit punch and began drinking it.

During a dining observation in the main dining room, beginning on 10/26/16 at 11:52 a.m., the following was observed:

At 11:52 a.m., meal tray service began for the twenty-one residents seated in the main dining room.

Resident #28 was seated at the table and received her meal at 12:01 p.m. She did not receive any assistance to begin eating.

Resident #11 was seated at the table and received her meal at 12:02 p.m. She did not receive any assistance to begin eating.

Resident #1 received her meal at 12:03 p.m. CNA #54 sat down next to her and began assisting her with her meal. The CNA indicated to the SSD that Resident #28 liked fruit punch and chocolate milk to drink. The SSD brought a cup of chocolate milk to the resident, sat it

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	above her plate without speaking to her, and walked over to speak to the DON at an adjacent table. At 12:07 p.m., the SSD returned to the dining room, accompanied by the ADON. At 12:11 p.m., the ADON sat next to Residents #28 and #11 to begin assisting them with their meals. Resident #28 had a 9/14/16, quarterly Minimum Data Set (MDS) assessment, which indicated her cognitive status was not assessable and she required extensive assistance with eating. Resident #1 had a 9/13/16, annual Minimum Data Set (MDS) assessment, which indicated her cognitive status was not assessable and she required extensive assistance with eating. Resident #11 had a 9/29/16, quarterly Minimum Data Set (MDS) assessment, which indicated she rarely or never made decisions and she required total assistance with eating. On 10/27/16 at 1:18 p.m., the ADON indicated Resident #28's ability to feed herself varied daily and staff would encourage her to do as much as she could by herself.			

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	3.1-3(t)			
F 0280 SS=D Bldg. 00	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. Based on observation, record review and interviews, the facility failed to update care plans regarding incontinence for 1 of 1 residents reviewed for a a decline in urinary continence (Resident #33) and nutritional and eating needs for 1 of 1 residents reviewed for activities of daily living. (Resident #28)	F 0280	F280 Right to participate in plan of care/updating care plans Resident #33 care plan will be updated to reflect current medical status and resident toileting needs. Resident #28 care plan will be updated to reflect her current dining/eating assistance needs. All current Resident's have the potential to be affected by the same deficient practice, therefore, the	11/27/2016

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	Finding includes: 1. The clinical record for Resident #33 was reviewed on 10/25/2016 at 1:18 p.m. Resident #33 was admitted to the facility on 08/31/12 with diagnoses, including but not limited to: constipation, dorsalgia, benign prostatic hypertrophy, anxiety disorder, hypertension, peripheral vascular disease, atherlosclerotic heart disease, edema, osteoarthritis, major depressive disorder, chronic obstructive pulmonary disease and dermatitis. A quarterly MDS (minimum data set) assessment, completed on 08/15/16, indicated the resident scored 3 of 15 on a BIMs (Brief interview of mental status) assessment, was severely cognitively impaired, required extensive staff assistance of one for transfers and wheelchair locomotion, and required extensive staff assistance of two staff for toileting needs. The resident was assessed to be frequently incontinent of his bladder. The resident was discharged to an acute care facility on 08/30/16. The resident was readmitted to the facility on 09/02/16 with diagnoses, including but not limited to: status post fractured femur and pneumonia.		MDS for all current residents will be reviewed to ensure that those residents that require assistance at mealtimes will have updated care plans indicating the level of assistance needed. Resident's MDSs will be reviewed to assess level of care needed for urinary continence management and the care plan will be reviewed to ensure it is updated with current urinary continence needs. Care plans addressing ADL assistance with eating and toileting to be reviewed quarterly by MDS Coordinator to ensure care plan accurately reflects MDS/Assessment Data. Kardex for C.N.A. care will be audited to ensure it includes the level of assistance needed with eating and toileting. Nursing staff to be re-educated on using the care plan and/or kardex to provide the appropriate care for the residents on 11/22/2016. 10% of resident care plans will be reviewed weekly by DON/Designee for 4 weeks, then monthly for 5 months. DON or designee will report findings to the Quality Assurance Committee monthly for 6 months for review and QA will be discontinued when continued substantial compliance achieved. All changes will be completed by 11/27/2016	

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	155444	A. BUILDING 00 B. WING	10/28/2016

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	A Quarterly MDS assessment, completed on 09/16/16, indicated the resident remained severely cognitively impaired, now required the extensive assistance of two staff for transfers and continued to require the extensive staff assistance of two for toileting needs. However, the resident had declined in bladder continency and was now always incontinent of his bladder. A bladder assessment, completed on 08/13/16, indicated the resident was not always but daily incontinent of his bladder, required the assistance of one staff to toilet, and was sometimes aware of his need to void. There was no predisposing factors and no identified pattern and no toileting program was "warranted." The subsequent bowel and bladder assessment, completed on 09/19/16, indicated the resident voided appropriately but was continent less than daily, required assistance of one staff for toileting needs, was confused and needed prompted, was sometimes aware of his need to toilet, had an undisclosed predisposing factor but it was treatable and under control. The care plan, last reviewed on 09/02/16 and current through 10/26/16 had			

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	interventions which had last been updated on 08/27/15. The interventions included the following: "Monitor and record bowel and bladder patterns each shift, use preferred elimination mode - uses toilet, assist with toileting one person physical assist, monitor/document/report PRN any possible causes of incontinence, bladder infection, constipation, loss of bladder tone, weakening of control muscles, decreased bladder capacity, diabetes, stroke, medication side effects, clean peri-area with each incontinence episode." There was no intervention put into place after the resident was noted to have declined in bladder continency. In addition, the care plan in place was not specific as to the resident's toileting needs. 2. During a dining observation in the main dining room, beginning on 10/24/16 at 11:55 a.m., the following was observed: At 11:58 a.m., Residents #28's meal tray was placed in front of her. No assistance was given to begin eating her meal. At 12:05 p.m., CNA #50 was standing next to her, as she was staring forward, and asked her to pick up her spoon and			

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	take a bite. When she did not pick up the spoon, she sat next to her and offered her a bite of food. At 12:12 p.m., CNA #50 again asked her to pick up her spoon and take a bite, as she walked away from the table. The resident continued to stare forward. At 12:30 p.m., CNA #52 sat next to her and asked if she was hungry. She indicated she was and began accepting bites of food offered from the CNA. She then accepted a small cup of chocolate milk that was placed in her hand and drank it in three swallows. She then accepted a small cup of fruit punch and began drinking it. During a dining observation in the main dining room, beginning on 10/26/16 at 11:52 a.m., the following was observed: Resident #28 was seated at the table and received her meal at 12:01 p.m. She did not receive any assistance to begin eating. At 12:11 p.m., the ADON sat next to her and began assisting her with her meal. She had not eaten any of the meal on her own. A 9/14/16, quarterly Minimum Data Set (MDS) assessment, indicated her			

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	cognitive status was not assessable and she required extensive assistance with eating. A current care plan, dated 4/30/15 and updated on 6/22/16, indicated she required set up help only and cueing with meals. A nutritional risk assessment, dated 9/14/16, indicated the facility would continue to encourage at least 50% intake every meal. On 10/27/16 at 1:18 p.m., the ADON indicated the resident's ability to feed herself varied daily, but she did require more than set up help only. 3.1-35(d)(2)(B)			
F 0282 SS=D Bldg. 00	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on interview and record review, the facility failed to follow physician	F 0282	F282 Services provided by Qualified persons per care plan Nurse Practitioner notified that	11/27/2016

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	orders for administration of medications with parameters related to blood pressure medication for 1 of 5 residents reviewed for unnecessary medication (Resident #57). Findings include: Resident # 57's clinical record was reviewed on 10/27/16 at 8:50 a.m. Her diagnoses included, but were not limited to, acute pulmonary edema and primary hypertension. She had a physician order, dated 10/2/16 thru 10/13/16, for Clonidine (blood pressure medication) 0.2 mg (milligrams) as needed for hypertension (high blood pressure). The order indicated to give the medication for blood pressure greater than 160/90. The Medication Administration Record (MAR), dated from 10/01/16 - 10/27/16, indicated that she received the Clonidine on 10/5/16 for a blood pressure of 177/67. During an interview with the Assistant Director of Nursing (ADON), on 10/27/16 at 1:20 p.m., she indicated the nurse gave the medication for a blood pressure based on the systolic (top number of blood pressure) pressure only.		Clonidine was given to Resident #57 on 10/5/2016 for a blood pressure reading of 177/67, when MD order was for Clonidine 0.2mg to be given as needed for a blood pressure reading of 160/90 or greater. Nurse Practitioner did indicate to Director of Nursing that the concern for this resident would have been her systolic blood pressure reading of 177. Resident #57 returned from the hospital on 10/13/2016 and the order for as needed Clonidine was not reinstated. Residents that are prescribed as needed antihypertensive medications will be audited to ensure that they have not been given as needed antihypertensive medications in error within the last 3 months. If given incorrectly MD and/or Nurse Practitioner will be notified and appropriateness of as needed antihypertensives will be evaluated. Nurses will be educated on following MD orders in regards to medication administration on 11/22/2016. DON or designee will run vital sign summary report for blood pressure readings and report will be monitored during morning clinical meeting Monday through Friday to identify any blood pressures that are greater than specified parameter and follow up will be completed to ensure that any with an as needed hypertensive medication were given the medication appropriately. This will be done daily for 4 weeks	

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	Policy was requested on 10/27/16 at 1:20 p.m. No further information was provided by time of exit. 3.1-35(g)(2)		Monday through Friday, weekly for 4 weeks and monthly for 3 months. DON or designee will report findings to Quality Assurance Committee monthly for 6 months for review and QA will be discontinued when continued substantial compliance achieved. All changes will be completed by 11/27/2016	
F 0309 SS=D Bldg. 00	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on record review and interview, the facility failed to assess a change of condition related to elevated blood pressures for 1 of 5 residents reviewed for unnecessary medications. (Resident #50). Findings include: The clinical record for Resident #50 was reviewed on 10/26/16 at 9:51 a.m. The resident had diagnoses which included, but were not limited to, cerebrovascular disease, cerebral infarction due to unspecified occlusion or stenosis of unspecified cerebral artery, edema and hypertension.	F 0309	F309 Provide Care and services for highest well being Resident #50 Nurse Practitioner notified by DON/Designee on 10/27/2016 of resident #50 blood pressure readings. Resident #50 blood pressure evaluation times changed after discussion with Nurse Practitioner to ensure a more accurate blood pressure measurement. Administration time changes were made to resident #50's blood pressure medications. Residents that are prescribed blood pressure medications have the potential to be affected by the same deficient practice. Residents that are prescribed blood pressure medications will be audited for	11/27/2016

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	The review of the resident's "Weights and Vitals Summary" indicated the following blood pressures: a. On 10/22/16 at 7:57 a.m., it was 163/99 mmHg [millimeter of mercury]. b. On 10/20/16 at 7:40 a.m., it was 173/107 mmHg. c. On 10/19/16 at 7:28 a.m., it was 159/101 mmHg. d. On 10/5/16 at 7:44 a.m., it was 168/106 mmHg. e. On 10/2/16 at 8:13 a.m., it was 165/105 mmHg. f. On 9/26/16 at 7:48 a.m., it was 162/107 mmHg. g. On 9/18/16 at 7:49 a.m., it was 171/101 mmHg. h. On 9/7/16 at 8:03 a.m., it was 174/84 mmHg. i. On 9/4/16 at 6:08 p.m., it was 182/78 mmHg. j. On 9/4/16 at 7:51 a.m., it was 186/82 mmHg. The review of the nurses' notes on 10/20/16 at 2:30 p.m.., indicated "Resident c/o [complain of] feeling tired today. Did vomit x [times] 1 before breakfast, but states she feels better now...." The clinical record lacked documentation		blood pressure readings outside of parameters. MD or Nurse Practitioner will be notified of audit findings and any changes in medication regimen will be initiated. Residents that are prescribed blood pressure medications will be assessed prior to giving blood pressure medications. If systolic blood pressure is greater than indicated parameter, medication will be given per Physician's order and nurse will reassess blood pressure reading in approximately 30 minutes. MD or Nurse Practitioner will then be notified if BP reading continues to be above parameter. Nurses to be educated on expectations of Physician Notification of Changes on 11/22/16. DON or designee will run vital sign summary report for blood pressure readings and report will be monitored during morning clinical meeting Monday through Friday to identify any blood pressures that are greater than physician specified parameter and follow up will be completed to ensure MD or Nurse Practitioner notification was completed. This will be completed 5 times a week for 4 weeks, then weekly for 4 weeks, then monthly for 4 months to ensure substantial compliance achieved. DON or designee will report findings to Quality Assurance Committee monthly x 6 months for review and QA will be discontinued when	

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	of reassessments regarding the resident's elevated blood pressures. During an interview with the Director of Nursing on 10/27/16 at 9:30 a.m., she indicated the resident's elevated blood pressures should be reassessed. During an interview with the Nurse Consultant on 10/27/16 at 10:08 a.m., she indicated there were blood pressures definitely out of the resident's normal baseline and the staff should have reassessed the elevated blood pressures. The Nurse Consultant indicated there were no reassessments of the elevated blood pressures found. During an interview with the Nurse Practitioner on 10/27/16 at 11:06 a.m., she indicated the resident's baseline blood pressure range was 140's systolic and 80's diastolic. The Nurse Practitioner indicated the nurse should have reassessed the blood pressure if it was greater than 165 systolic. During an interview with the Assistant Director of Nursing on 10/27/16 at 11:15 a.m., she indicated the nurse was the one who would assess the resident's blood pressure. A current facility policy titled "Blood		continued substantial compliance achieved. All systemic changes will be completed by 11/27/2016.	

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	Pressure Measurement", dated 2006, provided by the Nurse Consultant on 10/27/16 at 10:56 a.m., indicated the following: "...PURPOSE To obtain a measurement of the amount of pressure blood exerts against the walls of an artery. To assess change in condition. To assess effectiveness of medication...." No further information was provided by exit on 10/28/16. 3.1-37(a)			
F 0315 SS=D Bldg. 00	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.			

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	Based on observation, record review and interviews, the facility failed to ensure 1 of 1 residents reviewed for a a decline in urinary continence was thoroughly assessed and interventions implemented to restore as much bladder continency as possible. (Resident #33) Finding includes: The clinical record for Resident #33 was reviewed on 10/25/2016 at 1:18 p.m. The resident was admitted to the facility on 08/31/12 with diagnoses, including but not limited to: constipation, dorsalgia, benign prostatic hypertrophy, anxiety disorder, hypertension, peripheral vascular disease, atherlosclerotic heart disease, edema, osteoarthritis, major depressive disorder, chronic obstructive pulmonary disease and dermatitis. A quarterly MDS (minimum data set) assessment, completed on 08/15/16, indicated the resident scored 3 of 15 on a BIMs (Brief interview of mental status) assessment, was severely cognitively impaired, required extensive staff assistance of one for transfers and wheelchair locomotion, and required extensive staff assistance of two staff for toileting needs. The resident was assessed to be frequently incontinent of his bladder.	F 0315	**F315 No Catheter, Prevent UTI, Restore Bladder** Resident #33 will be reassessed to ensure his comprehensive assessment indicates accurate assessment of urinary incontinence. Resident #33's urinary incontinence will be managed per continence maintenance program policy. Nursing staff will use a communication dry erase board if necessary to communicate with Resident #33 regarding his need to use the restroom giving this resident the opportunity to void on the toilet. Residents in the facility have the potential to be affected by the same deficient practice. Resident's will have updated bladder assessments to ensure that the assessment accurately reflects the resident's current continence status to ensure plan of care is appropriate for the resident. Residents will have updated bladder assessments to ensure appropriate continence management. MDS coordinator or designee will complete bladder assessments, at a minimum quarterly, to ensure resident urinary continence status is treated appropriately. Resident's bladder continence will also be evaluated by the interdisciplinary team during interdisciplinary team walking rounds. Nurses will be educated on 11/22/2016 on Bladder assessments, supervision of staff regarding toileting residents and management of incontinence.	11/27/2016

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	The resident was discharged to an acute care facility on 08/30/16. The resident was readmitted to the facility on 09/02/16 with diagnoses, including but not limited to: status post fractured femur and pneumonia. A Quarterly MDS assessment, completed on 09/16/16, indicated the resident remained severely cognitively impaired, now required the extensive assistance of two staff for transfers and continued to require the extensive staff assistance of two for toileting needs. The resident had declined in bladder continency and was now always incontinent of his bladder. A bladder assessment, completed on 08/13/16, indicated the resident was not always, but daily was incontinent of his bladder, required the assistance of one staff to toilet, and was sometimes aware of his need to void. There were no predisposing factors, no identified pattern and no toileting program was "warranted." The subsequent bowel and bladder assessment, completed on 09/19/16, indicated the resident voided appropriately but was continent less than daily, required assistance of one staff for toileting needs, was confused and needed		Nursing assistants will be educated on 11/22/2016 regarding incontinence management, toileting residents and documentation of toileting. Quality Assurance tool to be completed by DON or designee to ensure that toileting plans are in place for residents that need them and that the plan is being followed, weekly for 4 weeks, monthly for 3 months. DON or designee will report findings to Quality Assurance Committee monthly for 6 months for review and QA will be discontinued when continued substantial compliance achieved. All changes will be completed by 11/27/16.	

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	prompted, was sometimes aware of his need to toilet, had an undisclosed predisposing factor but it was "treatable' and "under control." The care plan, last revised on 08/27/15 and current through 10/26/16, indicated the resident required staff assistance of one for toileting assistance, used the preferred elimination mode uses toilet, was to be monitored and bowel and bladder patterns were to be recorded each shift, was to be monitored for any possible causes of incontinence, and was to have his peri area cleansed with each incontinence episode. Resident #33 was observed on 10/26/16 at 8:45 a.m. in his wheelchair by the front lounge area, asleep. He remained in the same area and position until 9:00 a.m., when he was pushed in his wheelchair to his room and positioned beside his bed by CNA #31. He remained in his room in his wheelchair, without being offered or taken to the bathroom from 9:00 a.m. - 11:03 a.m; At 11:03 a.m., the Housekeeping Supervisor and CNA #31 pulled Resident #33 up in his wheelchair. He was not offered or taken to the bathroom. He was then taken to the dining room by CNA #31. At 11:24 a.m., Resident #33 was observed to propel his wheelchair from the dining room, across			

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	the front door area down the the front resident lounge area and then back to the dining room. At 11:35 a.m. - 12:30 p.m., the resident was observed seated in his wheelchair at a table in the dining room. The resident was observed on 10/27/16 at 8:10 a.m. in his wheelchair in the dining room eating his breakfast. A 8:20 a.m., he was pushed in his wheelchair to his room and positioned beside his bed by the DON (Director of Nursing). At 8:51 a.m., the resident pulled the call light cord out of the wall and when CNA #32 answered the light, the resident stated "I'm ready to go into the bathroom, I have to poop." CNA #32 then assisted the resident to the toilet by herself. She indicated the resident did void. The resident then remained in his wheelchair in his room until 9:40 a.m., when he wheeled himself into the hallway. He remained in the hallway and finally propelled himself by the front lounge and was by the Administrative offices when he was pushed to the activity room by the ADON (Assistant Director of Nursing) at 10:18 a.m. He remained in the Activity room until 11:10 a.m., when he was noted to be assisted to the dining room. He remained in the dining room and was served beverages and given a clothing protector by the Maintenance Supervisor at 11:25 a.m. He was still in the dining			

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	room eating his lunch meal until he was pushed from the dining room to the front lounge by the Director of Nursing at 12:51 p.m. At 1:00 p.m. he was pushed to his room by the Maintenance Supervisor and his wheelchair was positioned next to his bed. He remained in his room without any cues, prompts, or assistance to the toilet from 1:00 p.m. - 2:36 a.m., when he was assisted to the toilet by CNA #33. The resident was noted to have a very saturated brief but was able to void in the toilet. He was very hard of hearing and his daughter was noted to finally communicate the need to take him to the bathroom by writing the care need on a dry erase board. During an interview, on 10/27/16 at 1:30 p.m., CNA #32 indicated there was an electronic "Kardex" on Point of Care (electronic charting system for CNAs) where there were care instructions. During an interview with CNA #33, on 10/27/2016 at 2:13 p.m., she indicated the resident should be toileted about every two hours but depending on the day, he would also let them know sometimes when he needed to toilet. The electronic "Kardex" information for Resident #33, provided by the ADON on 10/28/16 at 8:42 a.m. indicated the			

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	resident required the assistance of one staff for toileting, his bowel and bladder patterns were to be monitored and recorded, and his preferred method of toileting was "uses toilet." There were no specific instruction regarding how frequently the resident was to be toileted. Electronic documentation of the resident's elimination record for 10/26/16 and 10/27/16 indicated there was no record of the resident being toileted on the day shift for either day. From 10/01/16 - 10/27/16, there were 11 days where the resident was not documented as having been toileted at all during the "Day" shift hours. When there was documentation recorded, it was only one time per eight hour shift. During an interview with the Regional nursing consultant, RN #34 on 10/28/16 at 10:23 a.m., she indicated there was no toileting plan in place for Resident #33 and there was also no patterning documentation available for the resident. She indicated the MDS (Minimum Data Set) nurse was in a meeting in another building and was not available to explain why the bowel and bladder assessments regarding the staff needs for toileting did not match the MDS assessment and what the predisposing factor indicated on the September assessment was and how it			

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	might have affected the resident's decline in continency. The facility policy and procedure, titled "Continence Maintenance Program", dated August 2014 and provided by the ADON on 10/28/16 at 8:42 a.m., included the following: "...4. Throughout residents stay, complete a Bowel and Bladder Assessment and Management Evaluation within 14 days of: (1) Admission or re-admission with identified incontinency; (2) Newly developed symptoms of incontinency; (3) Catheter removal; (4) MDS coding change in section H0300 or H0400 for Incontinency (when compared to prior assessment) (5) and per individual state requirements. 5. Select the most appropriate management program based on assessed parameters and implement interventions to address's identified needs. Management programs include Bowel and Bladder Re-training, Prompted or Scheduled Toileting (Habit Training), and Incontinence Management....8. Through the RAI (Resident Assessment Instrument), identify possible reversible problems and contributing factors for incontinence. Determine the type of urinary incontinence, so that individualized programming can be provided to enhance the resident's quality of life and			

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	functional status...." 3.1-41(a)(2)			
F 0431 SS=D Bldg. 00	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package			

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	drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, interview, and record review, the facility failed to ensure the security of narcotics and controlled substances in 1 of 2 medication carts. (300 Hall Medication Cart) Findings include: During an observation of the medication cart, with LPN # 59 on the 300 Hall on 10/26/2016 at 9:35 a.m., the narcotic box was found to be unlocked. The medications in narcotic box included, but not limited to, Morphine Sulfate (pain medication), Phenobarbital (antiseizure medication), Lorazepam (antianxiety medication) and Methadone (pain medication). LPN # 59 indicated the narcotic box should have been locked. On 10/28/2016 at 9:36 a.m., the Administrator provided a document that indicated there were 12 residents who had medications in the narcotic box on the 300 Hall. The "Storage and Expiration of Medications, Biologicals, Syringes and Needles" policy, dated, 01/01/2013 was provided by the Nurse Consultant on 10/26/2016 at 10:27 a.m., indicated the	F 0431	F 431 Drug Storage Nurse #59 was reeducated per Assistant Director of Nursing on proper locking of narcotic storage drawer in the medication cart. Residents with narcotic medications being stored in the 300 hall cart were not affected by the deficient practice. The resident's that had the potential to be affected by the same deficient practice were the residents whose controlled substances were being stored in the cart. These residents were not affected as the controlled substances were reconciled with the controlled substance record were locked in the medication cart with the external cart lock and there was not any discrepancy in the documentation. Nurses will be educated on 11/22/2016 regarding medication storage. DON or Designee will review medication carts 3 times per week for 4 weeks, then monthly for 5 months to ensure that narcotic medications are stored in a separate locked compartment in the locked medication cart. Negative findings will be corrected immediately. DON or designee will report findings to Quality Assurance Committee monthly for 6 months for review and QA will be discontinued when continued substantial compliance	11/27/2016

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	following: "... 3. General storage Procedures: 3.1 Facility should store Schedule ll controlled substances and other medications deemed by Facility to be at risk for abuse or diversion in a separate compartment within the locked medication cart and should have a different key or access device...." 3.1-25(n)		achieved. Completion date 11/27/2016.	
F 0441 SS=D Bldg. 00	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program			

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	determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.			
	Based on observation, record review and interviews, the facility failed to ensure infection control measures were utilized during 2 of 2 licensed staff (LPN #30 and the ADON) observed providing pressure ulcer treatments to 2 of 3 residents reviewed for pressure ulcers. (Resident #13 and 71) Findings include: 1. During the observation of the pressure ulcer treatment for Resident #13, provided by LPN #30 on 10/27/16 at 9:08 a.m. the following was noted: LPN #30 gathered her supplies and entered Resident #13's room. She then placed her supplies directly onto the resident's over bed table. Next, she	F 0441	F 441 Infection Control Resident #71 no longer resides in facility. Resident #30 continues to reside here. A barrier will be placed on his bedside table prior to preparing the field for the clean dressing change/wound treatment. Bandage scissors will be cleaned with alcohol prior to placing the scissors on the barrier. Bandage scissors will be cleaned with alcohol directly after using them to remove the old bandage and placed back on the barrier on the over bed table. Handwashing will be done prior to procedure. Handwashing or alcohol gel to be completed after removal of old dressings and handwashing after the treatment will be completed. LPN #30 was educated regarding proper infection control measures during dressing changes on 10/27/2016. Residents receiving wound	11/27/2016

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	washed her hands and donned a pair of gloves. She then pulled down the resident's shorts and removed the old dressings and placed them in a waste container. She also removed her gloves and washed her hands again in the resident's bathroom. She then donned a pair of gloves and picked up the packaged dressing material from the over-bed table. After opening the packaging, which had been laying on the unclean over-bed table, LPN #30 reached into the pocket of her uniform to obtain a pair of scissors. Without cleaning the scissors, she then cut a small square of calcium alginate dressing and wadded it up in palm of her left hand. She then picked up the border gauze packaged dressing and used both hands to open the package. She then again reached into her scrub top and obtained her scissors, cut a small slit on the side of the border gauze dressing. Next, LPN #30 placed the small square of calcium alginate dressing, which she had been holding, wadded in her left palm, directly onto the resident's open pressure area and then covered the dressing with the border gauze dressing. The undated facility policy and procedure, titled "Dressing Change, Clean," provided by the ADON on		treatments that have the potential to be affected by the same deficient practice will have a barrier placed on the over table (or other set up surface) prior to setting up the clean treatment field. Proper handwashing and equipment disinfecting will be completed during the treatments. Nurses will be re-educated on 11/22/16 regarding infection control practices during wound treatments. Observation of dressing change will be completed by DON or designee weekly for 4 weeks, monthly for 3 months and quarterly thereafter to ensure proper infection control practices are maintained. DON or designee will report findings to Quality Assurance Committee monthly for 6 months for review and QA will be discontinued when continued substantial compliance achieved. Completion date 11/27/2016.	

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	10/28/16 at 8:42 a.m., included the following instructions: "...2. Create clean field with paper towels or towelette drape...4. Open dressing pack. 5. Put on first pair of disposable gloves...." There were no instructions regarding the use of scissors or how to retrieve items from a uniform pocket. 2. The clinical record for Resident #71 was reviewed on 10/25/16 at 3:06 p.m. The resident had diagnoses which included, but were not limited to, pressure ulcer of sacral region and hypotension. During an observation of a pressure ulcer treatment with the Assistant Director of Nursing (ADON) for Resident #71 on 10/25/16 at 4:15 p.m. the following was observed: a. The ADON was observed to enter the resident's room and move a bedside table with items closer to the resident's bed. b. She removed the items and placed them on the resident's bedside dresser. c. She then placed a handful of gloves on the table with no barrier and was not observed to wash her hands after she moved the items from the bedside table.			

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	d. She applied gloves from the bedside table and unfastened the resident's incontinent brief, which had a brown and yellow substance inside it. e. She removed her gloves and reapplied another pair from the bedside table. Then applied wound cleanser to a gauze pad and cleansed the pressure ulcer area and patted it dry with a gauze pad. f. Then measured the pressure ulcer area located on the resident's coccyx, changed her gloves and reapplied another pair of gloves from the bedside table and applied MetroGel (a topical medication used to decrease inflammation) to a gloved finger and applied it to the resident's pressure ulcer area. g. She then removed her gloves and reapplied another pair of gloves located on the bedside table and applied the calcium alginate (a dressing used to absorb fluids and promote healing) and covered the area with an abdominal (ABD) pad (a highly absorbent dressing used for padding and protection of wounds), removed her gloves and washed her hands. The ADON throughout the treatment was observed to continuously move and fold over the incontinent brief with the brown and yellow substance located inside of the brief.			

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	During an interview with the ADON on 10/25/16 at 4:39 p.m., she indicated she should have washed her hands prior to the pressure ulcer treatment, applying gloves, cleaning the wound, applying treatment and there should have been a barrier placed down on the bedside table. A current facility policy titled "Dressing Change, Clean", dated 2006, provided by the Nurse Consultant on 10/27/16 at 10:27 a.m., indicated the following: "...PURPOSE To protect wound. To prevent irritation. To prevent infection and spread of infection. To promote healing. ...PROCEDURE ...2. Create clean field with paper towels or towlette drape...." No further information was provided by exit on 10/28/16. 3.1-18(l)			

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F 9999 Bldg. 00	410 IAC 16.2-3.1-14 Personnel Each facility shall have specific procedures written and implemented for the screening of prospective employees. Specific inquiries shall be made for prospective employees. The facility shall have a personnel policy that considers references and any convictions in accordance with IC 16-28-13-3. This state rule was not met as evidenced by: Based on interview and record review, the facility failed to ensure criminal background checks were completed for 4 of 5 new employees whose files were reviewed. This deficiency had the potential to affect 40 of 40 residents residing at the facility. Findings include: Employee files, reviewed on 10/26/2016 at 2:00 p.m., indicated the following: LPN #40, hired 5/29/2016, had no criminal background check.	F 9999	F9999 Final Observations-Employee Files C.N.A. #41 is no longer employed at facility. Activity Assistant #42 has current background check in her file. Residents residing at the facility have the potential to be affected by the same deficient practice. Active employee files will be audited for appropriate background checks and be brought current. All hiring managers will be re-educated on required pre-employment background checks by Administrator in Management Team in-service on 11/22/2016. HR or designee will review all pre-hire files for required documentation prior to employment. Administrator or designee to audit all new hire packets weekly for 4 weeks, monthly for 3 months and quarterly thereafter until Quality Assurance Committee deems continued substantial compliance is achieved. Completion date 11/27/2016	11/27/2016

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	CNA #41, hired 4/22/2016, had no background check. Activity Assistant (AA) #42, hired 4/20/2016, had no criminal background check. CNA #43, hired 9/21/2016, had no current background check. During an interview with the Administrator on 10/26/2016 at 3:22 p.m., he indicated they have a new policy which indicated the facility could "forgo" the criminal background check if the employee had been terminated or quit within 90 days of the new hire date. During an interview with Business Office Manager (BOM) on 10/27/2016 at 1:58 p.m., she indicated she recently took over obtaining criminal background checks for new employees. The BOM indicated she did not have access to the system at this time to obtain the background checks. She indicated she submitted new hire information to a sister facility and they ran the background check for her. On 10/26/2016 at 3:22 p.m., the Administrator provided an email which indicated CNA #41 was terminated on 2/10/2016 and rehired 4/22/2016. The email indicated she had not been gone			

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	more than 90 days. On 10/28/2016 at 9:36 a.m., the Administrator provided the criminal history checks from the employee files requested. Included was a criminal history check for LPN #40, dated 5/3/2013, and a criminal history check for CNA #43, dated 4/13/2016. No other background checks were provided. The "Employee Selection and Hiring" policy, provided by the Administrator on 10/28/2016 at 10:23 a.m., indicated: "Policy: It is Covenant Care and its subsidiaries policy to follow standard procedures in the selection and hiring of employees. Purpose: To ensure a complete and uniform selection process... Terms...F. Applicable pre-employment screenings, such as...background check should be completed prior to hire and specifically in states where these requirements are mandatory...." Missing new hire criminal background checks were requested on 10/26/2016 at 3:22 p.m. and 10/27/2016 at 1:58 p.m. No further information was provided at the time of exit.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155444	A. BUILDING 00 B. WING	10/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORWOOD HEALTH AND REHABILITATION CENTER	3720 N NORWOOD RD HUNTINGTON, IN 46750

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	3.1-14(a)			