STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155511		A. BU	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING  STREET ADDRESS, CITY, STATE, ZIP CO		X3) DATE SURVEY  COMPLETED  06/13/2017		
	ROVIDER OR SUPPLIE	R AND REHABILITATION CENTER		830 S 6TH ST TERRE HAUTE, IN 47807			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)	ATE	(X5) COMPLETION DATE
F 0000							
Bldg. 00	State Licensure Survey dates: Ju 2017	nne 7, 8, 9, 12, and 13,	F 00	000			
	Facility number Provider numbe AIM number: 10	r: 155511					
	Census Bed Typ SNF/NF: 23 Total: 23	e:					
	Census Payor T Medicare: 4 Medicaid: 19 Other: 0 Total: 23	ype:					
		ies reflect State Findings nce with 410 IAC					
	Quality review of 2017.	completed on June 20,					
F 0157 SS=D Bldg. 00	483.10(g)(14) NOTIFY OF CHA (INJURY/DECLIN (g)(14) Notificatio	IE/ROOM, ETC)					

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

Any defiency statement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.

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

Facility ID:

TITLE

(X6) DATE

PRINTED: 07/26/2017 FORM APPROVED OMB NO. 0938-0391

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155511	(X2) MULTIPLE ( A. BUILDING B. WING	OO	(X3) DATE COMPI <b>06/13</b>	LETED
	ROVIDER OR SUPPLIER	ND REHABILITATION CENTER	830 S	ADDRESS, CITY, STATE, ZIP CODE 6TH ST E HAUTE, IN 47807		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	BE	(X5) COMPLETION DATE
IAU	(i) A facility must in resident; consult we physician; and not her authority, the number is-  (A) An accident impresults in injury and requiring physician.  (B) A significant of physical, mental, or is, a deterioration psychosocial status conditions or clinical conditions or clinical consequences, or of treatment; or  (D) A decision to the resident from the five status of the s	mmediately inform the with the resident's ify, consistent with his or resident representative(s)  volving the resident which do has the potential for intervention;  mange in the resident's per psychosocial status (that in health, mental, or us in either life-threatening cal complications);  retreatment significantly discontinue an existing due to adverse to commence a new form  ransfer or discharge the facility as specified in  motification under (i) of this section, the lee that all pertinent lifed in §483.15(c)(2) is wided upon request to the lest also promptly notify	IAU			DATE
	(B) A change in re	sident rights under				

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

Event ID:

VKEC11

Facility ID: 000446

If continuation sheet

Page 2 of 77

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 00 COMPLETED 155511 B. WING 06/13/2017 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 830 S 6TH ST TERRE HAUTE NURSING AND REHABILITATION CENTER TERRE HAUTE. IN 47807 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG  $\mathsf{TAG}$ Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). Based on record review and interview, F 0157 F157 07/13/2017 the facility failed to ensure the physician 483.10(g)(14) NOTIFY OF CHANGES was notified of abnormal movements of a (INJUR/DECLINE/ROOM, ETC) resident on psychotropic medications (Resident 9) and for significant weight A facility must immediately inform change (Resident 2), for 2 of 16 resident the resident; consult with the resident's physician; and notify records reviewed for physician consistent with his or her authority, notifications. the resident representative(s) when there is a significant change in the Findings include: resident's physical, mental, or psychological status (that is, a 1. Resident 9's record was reviewed on deterioration in health, mental, or psychological status in either 6/8/17 at 1:05 p.m. The physician's life-threatening conditions or orders, dated June 2017, indicated the clinical complications. resident's diagnoses included, but were not limited to, psychotic disorder and How will the corrective action depression. The resident's current be accomplished for those residents who are affected by this medication regimen included, but was not alleged deficient practice. limited to, quintenapine (antipsychotic medication) 300 mg (milligrams), give with 200 mg to equal 500 mg, at bedtime. -Resident #9 physician was notified An annual MDS (minimum data set) of the resident's score on the AIMS test, physician collaborated with assessment, dated 12/9/16, indicated the psychologist to discuss possible resident exhibited behavior symptoms medication changes, none were directed towards others, and had active made at that time. diagnoses that included, but were not limited to, psychotic disorder.

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

Event ID:

VKEC11

Facility ID: 000446

If continuation sheet

Page 3 of 77

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155511	B. WING	<del></del>	06/13/2017
			STREET	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	ROVIDER OR SUPPLIER	3	830 S 6		
TERRE H	HAUTE NURSING A	AND REHABILITATION CENTER		HAUTE, IN 47807	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
TAG	A care plan, data resident had the effects related to medications. Int were not limited that included, but EPS (extra pyrantardive dyskines movements).  An AIMS (abnormovement scale indicated the observation and carea of the residual than the observation of the perioral area of the perioral area of the puckering, pouting movements in an A review of medicated 6/28/16 the no documented in a contract of the perioral area of the puckering, pouting the perioral area of the perioral area.	ed 7/12/16, indicated the potential for adverse side of the use of psychotropic erventions included, but a to, monitor side effects at were not limited to, midal symptoms) and aia (involuntary body  rmal involuntary ) test, dated 12/1/16, servation of involuntary minimal muscles of facial of the lips and perioral ent's face.  lated 3/21/17, indicated of involuntary me resident's lips and his face with minimal sing, smacking and tongue and out of his mouth.  Intal health consult notes, rough 2/5/17, indicated notification of the	TAG	-Resident #2 physician was notified of resident's significant weight loss. Resident #2 care plan was also amended to reflect his desire to los weight.  2. How will the facility identify resident having the potential to be affected by the same deficient practice?  All residents in the facility could potentially be affected by this practice. However, the DON/designee will monitor 24 hr reports for physician notifications. MDSC reviewed all the care plans or residents identified abnormal involuntary movement scale scores and significant weight losses/gains to ensure care plans were being followed as written and reflect the current care treatment and services provided. All residents were reviewed for significant weight loss over the last 6 months and physician notification was madeon any that were identified.  3. What measures were put into place or systematic changes made to ensure the deficient practice notification or the deficient practice notification was made to ensure the deficient practice notification or the deficient practice notification was made to ensure the deficient practice notifica	e f
		ved involuntary abnormal		recur?	
	movements.			-On 6/26/17 All nursing staff were educated and in-serviced on	
		ress notes, dated		physician notification of significant	
	12/23/16 throug	h 4/17/17, indicated no		change of condition regarding	
	documented not	ification of the resident's		abnormal involuntary movement	

STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SUI			VEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPLETE	D
		155511	B. WI	ING		06/13/201	17
				CTDEET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIEF	₹		830 S 6			
TEDDE L	JALITE NI IDRING /	AND REHABILITATION CENTER			HAUTE, IN 47807		
TENNET	IAUTE NURSING A	AND REHABILITATION CENTER		IERRE	TIAUTE, IN 47807		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE CO	OMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	observed involu	ntary abnormal			scale (AIMS) and significant weight		
	movements.				gains/losses		
	Nurse's Notes, dated 3/9/17 through				-Nursing staff to document on 24 hr		
	•				report of any physician notifications		
		l no documentation of			related to significant changes o		
		cation of the resident's			conditions, including but not limited		
	observed involu	ntary abnormal			to AIMS and weight		
	movements.				gains/losses.		
					4. How will the facility monitor its		
	During an interv	riew on 6/9/17 at			corrective action?		
	_	ON (Director of Nursing)			corrective action:		
	· ·	as unsure if the physician			The DON/Designee is responsible fo	r	
		he AIMS test results for			monitoring 24 hr reports for		
					physician notifications of significant		
		and March 2017.			changes associated with weight loss		
	2. Resident 2's r	medical record was			and AIMS QAPI audits for four week		
	reviewed 6/9/17	at 11:45 a.m. An			and monthly for six months		
	admission record	d, dated 4/19/17,			thereafter until compliance is		
		s not limited to diagnoses			maintained for two consecutive		
		es without complications,			quarters. The results of these audits		
		-			will be reviewed by the QAPI		
		set cerebellar ataxia			Committee Monthly. If 95%		
		, unspecified dementia			compliance is not achieved, and		
	without behavior	ral disturbance, and			action plan will be developed and		
	gastro-esophage	al reflux disease without			implemented. Monthly QAPI		
	esophagitis.				minutes and action plans are		
	1 0				submitted to regional operations		
	Resident 2's wei	ght history indicated:			staff and corporate risk		
	1 Resident 2 5 Wei	511t mistory maioatea.			management team for review.		
	1/1/17 000	1					
	a. 1/1/17: 230 pc	ounds.			Date completed: July 3, 2017		
	b. 2/4/17: 218.1	pounds.					
	c. 4/10/17: 218.9	pounds.					
	d: 4/11/17: 219.	7 nounds					
	u. 4/11/1/. 219.	7 poulius.	1				

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

Event ID:

VKEC11 Facility ID: 000446

If continuation sheet

Page 5 of 77

PRINTED: 07/26/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			r í		NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		JILDING	00	COMPL	
		155511	B. WI			06/13/	2017
NAME OF P	PROVIDER OR SUPPLIER	t			ADDRESS, CITY, STATE, ZIP CODE		
TEDDE	IALITE NUIDOINO A	AND DELIADII ITATION CENTED		830 S 6			
		AND REHABILITATION CENTER		TERRE	HAUTE, IN 47807		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	· ·	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	ΓE	COMPLETION DATE
TAG	REGULATORT OR	LISC IDENTIF FING INFORMATION)		TAG			DATE
	e: 4/12/17: 219 p	oounds.					
	f: 5/6/17: 209.6 <sub>1</sub>	pounds.					
	a Undated first	week of June: 206					
	g. Ondated, first pounds.	week of June: 206					
	pounus.						
	A review of nurs	se's notes, from 3/8/17 to					
	6/12/17, did not						
	· ·	of physician notification					
	of significant we						
	or significant we	right 1055.					
	A care plan, crea	ated on 2/2/15, and last					
	_	17, included, but was not					
		is of resident had the					
	· ·	ritional problem related					
	to diagnosis of d	-					
	dementia, and ce	erebellar ataxia. The goal					
	was resident to r	naintain adequate					
	nutritional status	s as evidenced by					
	maintaining a we	eight within 5 percent of					
	the baseline weig	ght. Interventions					
	included, but we	ere not limited to, resident					
	needed a calm, q	uiet environment at meal					
	time, administer	ed medications as					
	ordered, provide	d and served diet as					
	ordered, and reg	istered dietitian evaluated					
		nange recommendations					
	as needed.						
		ss note, dated 2/21/17,					
	· ·	s not limited to, resident					
	had a significant	weight loss of 5.1					

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

Event ID:

VKEC11

Facility ID: 000446

If continuation sheet

Page 6 of 77

PRINTED: 07/26/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155511		(X2) MULTIPLE A. BUILDING B. WING	00	COM	TE SURVEY  MPLETED  13/2017			
	PROVIDER OR SUPPLIER	ND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE  830 S 6TH ST  TERRE HAUTE, IN 47807					
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SH	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			
	wanted to lose w with the weight in recommendation documentation w physician notification weight loss.	ys. Resident indicated he reight and was happy loss. No new as were made. No was included indicating ation of significant iew on 6/13/17 at 8:33						
	a.m., Licensed P indicated as soon there was a signiresident the physical At the same time chart and was un	ractical Nurse (LPN) 20 n as the nurse was aware ficant weight change in a sician would be notified. e, LPN 20 reviewed the hable to find any f physician notification						
	Director of Clinia document, date "Changes in Resindicated the polbeing used by the indicated, "The notified when changes in the rethe problem(s)/g	45 p.m., the Regional cal Operations provided ed April 2005, titled, ident Condition," and icy was the one currently e facility. The policy attending physicianare ranges in condition or curGuidelines:4. esident status that affect oal(s) or approach(es) on ans are documented"						
F 0165	483.10(j)(1)							

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

Event ID:

VKEC11

Facility ID: 000446

If continuation sheet

Page 7 of 77

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155511	(X2) MULTIPLE CONSTRUCTION       (X3) DATE SURV         A. BUILDING       00       COMPLETED         B. WING       06/13/2017			ETED	
		133311	B. W1			00/13/	2017
NAME OF P	ROVIDER OR SUPPLIEF	₹		830 S 6	ADDRESS, CITY, STATE, ZIP CODE		
TERRE H	HAUTE NURSING A	AND REHABILITATION CENTER			HAUTE, IN 47807		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		LISC IDENTIFYING INFORMATION)		TAG	DEFICIENCE		DATE
SS=D Bldg. 00	RIGHT TO VOICE WITHOUT REPRI						
Diag. 00		t has the right to voice					
		facility or other agency or					
	entity that hears g						
		reprisal and without fear of					
		reprisal. Such grievances are spect to care and					
		as been furnished as well					
		not been furnished, the					
		and of other residents, and					
	other concerns re	garding their LTC facility					
	stay.						
			F 01	65	F165		07/13/2017
	Based on intervi	ew and record review,			483 10(1)(1)DICHT TO VOICE		
	the facility failed	d to ensure access to			483.10(J)(1)RIGHT TO VOICE GRIEVANCES WITHOUT REPRISAL		
	eyeglasses for 1	of 2 residents reviewed			GILL VANCES WITHOUT REPRISAE		
	for missing item	s (Resident 2).			The resident has the right to voice		
					grievances to the facility or other		
	Findings include				agency or entity that hears		
	S				grievances without discrimination		
	During an interv	riew on 6/8/17 at 10:45			or reprisal and without fear of		
	_	indicated that his			discrimination or reprisal. Such		
	*	peen missing for 1 month.			grievances include those with		
		otified, but eyeglasses			respect to care and treatment which has been furnished as well as	,	
	had not been fou	, , ,			that which has not been furnished,		
	nau not occii iou	ma.			the behavior of staff and of other		
	Duning an inter	view on 6/0/17 the MDC			residents, and other concerns		
		riew on 6/8/17, the MDS			regarding their LTC facility stay.		
	`	Set) coordinator					
		as not aware of any			1. How will the corrective action be	•	
	missing items.				accomplished for those residents		
					who are affected by this alleged deficient practice.		
	_	riew on 6/8/17 at 2:35			dendent practice.		
	p.m., the Social	Services Director (SSD)			Resident #2 glasses had been		
	indicated she wa	as not aware of any			missing for approximately		
	missing items. V	When a resident had an				,	
	-		1		1month. However, resident #2	۷	

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

Event ID:

VKEC11 Facility ID: 000446

If continuation sheet Page 8 of 77

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUE		SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
		155511	B. W	ING		06/13/	2017
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	8		830 S 6			
TERRE I	HAUTE NURSING A	AND REHABILITATION CENTER			HAUTE, IN 47807		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	<u> </u>	TAG	DEFICIENCY)		DATE
	_	SSD was notified and a			glasses had been found in his		
	grievance form	was filled out.			bed, but then he lost them		
					again. Resident was offered to	)	
	During an interview on 6/8/17 at 2:41				see facility eye Dr, but		
	p.m., the Directo	or of Nursing (DON)			resident refused. Resident's		
	indicated Resident 2's eyeglasses had				sister was to take him to an		
	been lost. She th	hought they had been			eye appointment outside of		
		. She was unaware of the			the facility; however		
	eyeglasses still b	being missing.			appointment was canceled		
	١				• •		
	During an interv	riew on 6/9/17 at 11:44			due to that Dr not accepting		
		indicated his eyeglasses			resident's insurance. Facility		
	· ·	The eyeglasses were never			has attempted to contact		
	found. The staff				resident's family regarding		
					setting up an appointment,		
		vas unable to find them.			however family will not return	1	
		ntinuing to look for the			call.		
		and not offered to replace					
	them.						
	During an interv	riew on 6/13/17 at 8:33			2. How will the facility identify		
	_	Practical Nurse (LPN) 20			resident having the potential to be		
	· 1	s not aware of any			affected by the same deficient		
		-			practice?		
		ses. Resident had gone to					
	1	bout 2 months ago and			-All residents in the facility could		
	got new eyeglas	ses.			potentially be affected by this		
					practice. However, Social Service ha	S	
	_	riew on 6/13/17 at 8:36			made an appointment on 7/3/17 to get resident glasses replaced. All		
	a.m., Restorative	e Certified Nursing			residents were visited to ensure tha	t	
	Assistant (CNA)	12 indicated Resident	1		visual appliances were available to		
	2's eyeglasses w	ere lost and had not been			them as needed. Appointments will		
	found. The staff	f had looked throughout			be scheduled for those in need.		
	the facility and v	was unable to locate the	1				
		eyeglasses were lost			3. What measures were put into		
			1		place or systematic changes made		
	about a month and a half ago.		1		to ensure the deficient practice not		

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

Event ID:

VKEC11 Facility ID: 000446

If continuation sheet

Page 9 of 77

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SU			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
		155511	B. WI	NG		06/13/	2017
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER	t		830 S 6			
TERRE F	ALITE NURSING A	AND REHABILITATION CENTER			HAUTE, IN 47807		
				l	1,7,6,12, 11, 17,667		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	*	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION DATE
TAG	REGULATORT OR	LISC IDENTIFY THO INFORMATION)		TAG	recur?		DAIL
	Danidant Olamaa	4			recur:		
		ord was reviewed on			-On 6/26/17 all staff was		
	6/9/17 at 11:45 a.m. An admission				in-serviced on the grievance		
	record, dated 4/19/17, included but was				=		
	not limited to diagnoses of early onset				policy and the locations of		
	cerebellar ataxia (inflamed brain),				forms that grievances will be		
	unspecified dem	entia without behavioral			reported on.		
	disturbance, and	dry eye syndrome of			0.6/06/47. 0.11.10.11		
	unspecified lacri	mal gland.			-On 6/26/17 a Resident Council meeting was held to inform		
					residents of their rights to voice		
	An annual Minir	num Data Set (MDS)			grievances without fear of reprisal,		
	assessment, date	d 3/23/17, indicated			including but not limited to missing		
	-	cognitively intact.			items		
	Δ review of the	grievance log from			-Social Service Designee will monito	r	
		rough June 2017 did not			and log all grievances reported by		
	_	nce prior to 6/8/17			residents.		
	_	-			-Social Service Designee will report		
	regarding Reside	ent 2 s missing			in Daily QA meeting any grievances		
	eyeglasses.				that have been reported		
		.1					
	_	cy, identified as the one			4. How will the facility monitor its		
	, ,	used by the facility, titled,			corrective action?		
		rsing and Rehabilitation			To account association as the Contain		
		e Procedure," provided			-To ensure compliance, the Social Service Director is responsible for		
	_	/13/17 at 9:50 a.m.,			monitoring and logging all		
	included, but wa	s not limited to,			grievances and reporting all		
	"Purpose: To ens	sure the resident may			grievances QAPI audits weekly for		
	voice grievances	and make suggestions			four weeks and monthly for six		
		olicies and services to			months thereafter until compliance		
	-	outside representatives of			is maintained for two consecutive		
	_	out fear of reprisal,			quarters. The results of these audits		
		train, coercion, or			will be reviewed by the QAPI		
	-	The staff member should			committee monthly. If 95%		
					compliance is not achieved, an		
	assist iii soiving	the concern when able	1		action plan will be developed and		

AND PLAN O		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155511	JILDING	00	(X3) DATE ( COMPL 06/13/	ETED
	ROVIDER OR SUPPLIER	ND REHABILITATION CENTER	830 S 6	ADDRESS, CITY, STATE, ZIP CODE TH ST HAUTE, IN 47807		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
F 0272 SS=D Bldg. 00	and forward the gate Administrator and Director4. Once corrected or solve out the form, the the Social Service the complaint, the effort made to promaintained by the Director."  3.1-7(a)(1)  483.20(b)(1)  COMPREHENSIV (b) Comprehensive (1) Resident Asset facility must make assessment of a restrengths, goals, lipreferences, using instrument (RAI) sassessment must following:  (i) Identification and information (ii) Customary rociii) Cognitive patt (iv) Communication (v) Vision.  (vi) Mood and bed (vii) Psychological (viii) Physical problems.  (ix) Continence.	grievance to the d Social Service e the department has ed the concern and filled form will be given to be Director. A record of e plan of action, and the covide a solution will be e Social Services  E ASSESSMENTS e Assessments  E Assessments  E Assessments  E Assessments  E Assessments  E Assessment Instrument. A a comprehensive esident's needs, fe history and of the resident assessment pecified by CMS. The include at least the land demographic strength.  E Assessments  E Assessment Instrument. A a comprehensive esident's needs, fe history and of the resident assessment pecified by CMS. The include at least the land demographic strength of the resident assessment pecified by CMS. The include at least the land demographic strength of the resident assessment pecified by CMS. The include at least the land demographic strength of the resident assessment pecified by CMS. The include at least the land demographic strength of the resident assessment pecified by CMS. The include at least the land demographic strength of the resident assessment pecified by CMS. The include at least the land demographic strength of the resident assessment pecified by CMS. The include at least the land demographic strength of the resident assessment pecified by CMS. The include at least the land demographic strength of the resident assessment pecified by CMS. The include at least the land demographic strength of the resident assessment pecified by CMS. The include at least the land demographic strength of the resident assessment pecified by CMS. The include at least the land demographic strength of the resident assessment pecified by CMS. The include at least the land demographic strength of the resi	TAG	implemented. Monthly QAPI minutes and action plans are submitted to regional operations staff and corporate risk management team for review.  Date completed: July 3, 2017		DATE

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

Event ID:

VKEC11 Facility ID: 000446

If continuation sheet

Page 11 of 77

STATEMENT	OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE			SURVEY	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BU	ILDING	00	COMPL	ETED
		155511	B. WI	NG		06/13/	2017
TERRE HA		ND REHABILITATION CENTER		830 S 6 TERRE	ADDRESS, CITY, STATE, ZIP CODE TH ST HAUTE, IN 47807		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ſE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	TAG DEFICIENCY)			DATE	
(c)	exvi) Discharge (xvii) Document (xviii)	ursuit.  ons.  nents and procedures.  e planning.  ntation of summary ing the additional med on the as triggered by the Minimum Data Set (MDS).  ntation of participation in assessment process t tion and communication as well as communication as well as communication as well as communication insed direct care staff iffs.  rocess must include direct formunication with the as communication with icensed direct care staff iffs.  ation, interview, and as facility failed to ensure sment was done for a g oxygen therapy as t 10), to ensure a sessment was completed th pain (Resident 10), assess the type of fluid and (Resident 32) for 2 of ewed for accurate	F 02	272	F272  483.20(b)(1) COMPREHENSIVE ASSESSMENTS  Resident Assessment Instrument. A facility must make a comprehensive assessment of the resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS.  1. How will the corrective action be accomplished for those residents	e ,	07/13/2017

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

Event ID:

VKEC11 Facility ID: 000446

If continuation sheet Page 12 of 77

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
		155511	B. WI	ING		06/13/	2017
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIEF	8		830 S 6			
TERRE H	HAUTE NURSING A	AND REHABILITATION CENTER			HAUTE, IN 47807		
					17.612, 114 17667		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA'  DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	·		DATE
					who are affected by this alleged		
	1. On 6/12/17 at 10:11 a.m., Resident 10				deficient practice?		
	was observed wearing oxygen at 2 liters				Resident #10 order for Oxygen as		
	via nasal cannula	a while lying in bed.			needed will have documentation of		
					assessment,		
	During an interv	riew on 6/12/17 at 10:20			administration/refusal. O2		
	_	Practical Nurse (LPN) 9			saturation will be documented in		
	· · · · · · · · · · · · · · · · · · ·	ent 10 should wear			the TARs. DON/Designee to		
		me, but he refused at			monitor Oxygen administration O2		
					saturation documentation to ensure	2	
		10 wore oxygen when he			it is completed for all residents		
	_	gen administration			requiring Oxygen therapy.		
		nented on the Treatment			A		
		Record (TAR). If a			A pain assessment was completed on Resident #10 on 6/16/17		
		order for oxygen to be			011 Resident #10 011 0/10/17		
	given as needed	then the oxygen would			Resident #32 care plan was updated		
	be administered	if the resident had signs			to reflect he has no chewing and		
	or symptoms of	shortness of breath,			swallowing difficulties.		
	complained of sl	hortness of breath, or if					
	the resident requ	ested the oxygen. If as			2. How will the facility identify		
	_	was administered then an			resident having the potential to be		
		on should be checked and			affected by the same deficient		
		the TAR. Resident 10			practice?		
		administer oxygen to			-All residents in the facility could		
	himself.	diminister oxygen to			potentially be affected by this		
	1111115011.				practice. However, all residents that	:	
	Dutus 14	:			require oxygen administration will		
	_	riew on 6/12/17 at 10:44			be documented in the appropriate		
	-	or of Nursing (DON)			place. The care plans of all residents	;	
		eeded oxygen was given			with identified pain were reviewed		
		ation should be checked			by MDS to ensure care plans are		
	and documented	either in the nurse's			followed as written and reflect the		
	notes or on the T	TAR.			current care and services provided.		
					All resident's care plans were		
	Resident 10's red	cord was reviewed on			audited to ensure correct chewing and swallowing problems were		
		a.m. An admission			correct.		
	0, 5, 1, 40 11.17		1				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  00			(X3) DATE SURVEY COMPLETED	
		155511	B. WI	NG	_	06/13/2017
	PROVIDER OR SUPPLIER	ND REHABILITATION CENTER	•	830 S 6	ADDRESS, CITY, STATE, ZIP CODE STH ST HAUTE, IN 47807	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	record, dated 4/1 not limited to, didiastolic congest obstructive pulm unspecified, and disease of native angina pectoris.  A physician's ordindicated oxyger cannula as needed breath.  The TAR for Ap June 2017 did not documentation of administration, of oxygen.  Nurse's notes from not include any of the second controlled any of the second controlled and the second controlled any of the second controlled controlled any of the second controlled contr	9/17, included, but was agnoses of chronic live heart failure, chronic hea			3. What measures were put into place or systemic changes made to ensure that the deficient practice not recur?  -On 6/26/17 all Licensed Nursing Staff were in-serviced on the Oxygen Administration policy and documenting O2 saturation on the TARs.  -On 6/26/17 all Licensed Nursing Staff were in-serviced on the Pain Assessment Policy, performing pain assessments and reassessments and documenting the level and the location of the pain resident is experiencing.  -All resident's nutritional assessments were reviewed/revised for residents with chewing/swallowing difficulties by Dietary Manager and MDSC.	n d
	revised 5/15/17, limited to a focut for exacerbation pulmonary diseat oxygen as needed oxygen at times, staff has to reapp Interventions income.	ated 8/31/16, and last included but was not s of resident was at risk of chronic obstructive se. Resident had use of d. Resident did refuse will take off himself and oly frequently.			-DON/Designee to monitor Oxygen documentation in TARs.  -DON/Designee to perform random audits of pain assessments/reassessments, level or pain and location of pain per Pain Assessment Policy  4. How will the facility monitor its corrective action?	ıf

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

Event ID:

VKEC11 Facility ID: 000446

If continuation sheet Page 14 of 77

PRINTED: 07/26/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION IDENTIFIC	CATION NUMBER:	A. BU	ILDING	00	COMPLE	ETED
	155511		B. WI	NG		06/13/2	2017
			Ь,	CTDEET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER						
TEDDE L	HAUTE NURSING AND REH	ADII ITATION CENTED		830 S 6	HAUTE, IN 47807		
IERREF	IAUTE NURSING AND REH	ABILITATION CENTER		IERRE	HAUTE, IN 47607		
(X4) ID	SUMMARY STATEMENT	OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST F	BE PRECEDED BY FULL	1	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR LSC IDENT	TIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	sounds as needed, oxyge	n as per			-To ensure compliance, DON is		
	physician's order, oxyger	n saturations as			responsible for monitoring Oxygen		
	needed, and staff to reap				documentation in the TARs,		
		pry oxygen			conducting random audits of pain		
	frequently.				assessments/re-assessments, level		
					of pain, and documentation of the		
	An annual Minimum Dat	` ′			location of pain per Pain Assessmen	t	
	assessment, dated 8/11/1	6, included, but			Policy QAPI audits weekly for four		
	was not limited to, Resid	ent 10 had			weeks and monthly for six months		
	received oxygen therapy				thereafter until compliance is		
	in the facility.	.,			maintained for two consecutive		
	in the facility.				quarters. The results of these audits		
	0 (12/17 + 0.52	d D ' 1			will be reviewed by the QAPI		
	On 6/13/17 at 9:53 a.m.,	· ·			committee monthly. If 95%		
	Director of Clinical Oper	rations provided			compliance is not achieved, an		
	a document, dated Decen	nber 2010, titled,			action plan will be develop and		
	"Oxygen Administration	," and indicated			implemented. Monthly QAPI		
	the policy was the one cu				minutes and action plans are		
	used by the facility. The				submitted to regional operations		
		•			staff and corporate risk		
	"A resident will need oxy				management team for review.		
	hypoxemia (low oxygen	•			Data Canadata da Julia 3, 2017		
	Oxygen saturation monit	oring will			Date Completed: July 3, 2017		
	determine the adequacy of	of oxygen					
	therapyPROCEDURE:	5. Monitor the					
	residents response to oxy						
	Check pulse oximetry va						
	•	•					
	initial adjustments of oxy	gen flow"					
	2. Resident 10's record v	vas reviewed on					
	6/9/17 at 11:17 a.m. An	admission					
	record, dated 4/19/17, inc	cluded, but was					
	not limited to, diagnoses						
	mellitus, peripheral vasci						
	, I I	The state of the s					
	muscle spasm of the back	k, depression,					
	and low back pain.						

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

Event ID:

VKEC11 Facility ID: 000446

If continuation sheet Page 15 of 77

PRINTED: 07/26/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			r í		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY  A. BUILDING 00 COMPLETED				
		155511	B. Wl	NG		06/13/	2017		
NAME OF F	PROVIDER OR SUPPLIER			STREET A	DDRESS, CITY, STATE, ZIP CODE				
TERRE H	HAUTE NURSING A	AND REHABILITATION CENTER			HAUTE, IN 47807				
(X4) ID PREFIX	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES  CY MUST BE PRECEDED BY FULL  LEG INFORMATION		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ſΕ	(X5) COMPLETION		
TAG	A physician's ordindicated acetam medication) 325 tablets by mouth for mild pain.  A physician's ordindicated hydroc (pain medication by mouth every severe pain.  Acetaminophen back pain. There pain severity and pain.  Acetaminophen pain of 6 on a pain seessessment. The location of the Acetaminophen pain of 6 on a pain of 5 on a pain of 6 on a pain of 5 on a pain	milligrams (mg), give 2 every 6 hours as needed  der, dated 11/4/16, odone/acetaminophen a) 5/325 mg, give 1 tablet 4 hours as needed for  was given on 4/7/17 for e was no indication of I no reassessment of  was given on 5/18/17 for in scale of 1-10. Pain scale of 1-10 upon here was no indication of the pain.  was given on 6/6/17 for in scale of 1-10 upon here was no indication of the pain.  was given on 6/11/17 for in scale of 1-10. Pain		TAG	DELICIENCI)		DATE		

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

Event ID:

VKEC11

Facility ID: 000446

If continuation sheet Page 16 of 77

PRINTED: 07/26/2017 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		· ′	ULTIPLE CO JILDING	00	COMPL		
		155511	B. W	ING		06/13/	2017
NAME OF I	PROVIDER OR SUPPLIER			STREET A 830 S 6	ADDRESS, CITY, STATE, ZIP CODE		
TERRE H	HAUTE NURSING A	AND REHABILITATION CENTER			HAUTE, IN 47807		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	·	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
	revised on 5/15/limited to a focu for pain. The go limited to reside comfort with integration pain medications but were not lim analgesia as per before treatment effectiveness of monitor/docume each pain episod side effects of pamonitor/record princluding quality location, onset, of factors, and relied An annual minimassessment, date Resident 10 had occasionally and scale of 1-10.  During an interval. Resident 10 had pain. He did up and during capain medication.	pain characteristics v, severity, anatomical duration, aggravating eving factors.  num data set (MDS) d 8/11/16, indicated pain in the last 5 days rated it at 7 on a pain liew on 6/12/17 at 10:11 0 indicated he frequently d have pain when he got are. Staff did not offer					

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

Event ID:

VKEC11 Facility ID: 000446

If continuation sheet

Page 17 of 77

PRINTED: 07/26/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFIC		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155511	r í	JILDING	onstruction  00	(X3) DATE COMPI 06/13	LETED
	JRSING A	ND REHABILITATION CENTER		830 S 6	ADDRESS, CITY, STATE, ZIP CODE TH ST HAUTE, IN 47807		
PREFIX (EAC	H DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE	(X5) COMPLETION DATE
indicate pain me treatme given fi if the accompany a.m., the indicate pain assepain me and rear effective Resider prior to at 8:21 his room. The pite water. It problems the problems of the p	an interverse Director da pain essessment dication eness shout 10 did etreatment a.m., Resent director de vide en director de la pain essessment en director de la pain en di	not regularly provide to Resident 10 prior to a. Acetaminophen was recodone would be given when was not effective.  New on 6/12/17 at 10:44 or of Nursing (DON) scale of 1-10 is used for when an as needed was given type, location, at for medication wild be documented. The not need pain medication to reare. 3. On 6/13/17 ident 32 was observed in a g from his water pitcher. The regular, non-thickened are of swallowing		IAG			DATE
swallov During	ving was an interv	culty with chewing or observed.  iew, on 6/13/17 at 8:28 language pathologist					

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

Event ID:

VKEC11 Facility ID: 000446

If continuation sheet

Page 18 of 77

PRINTED: 07/26/2017 FORM APPROVED OMB NO. 0938-0391

	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155511	(X2) MULTIPLI A. BUILDING B. WING	E CONSTRUCTION  G 00	CON	TE SURVEY  MPLETED  13/2017		
	PROVIDER OR SUPPLIEF	AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE  830 S 6TH ST  TERRE HAUTE, IN 47807					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO) CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE		
	speech therapy s The resident had swallowing or cl no order for thic mechanically alt current diet orde  During an interv a.m., the MDS C resident had no cl problems and rec liquids. The resident of the Resident 32's rec 6/12/17 at 1:36 g orders, dated Jur resident's diagnor not limited to, er schizophrenia, a  The resident was independent was independent was independent of the classification of the company	newing problems and had kened liquids or ered diets. The resident's r was for a regular diet.  iew, on 6/13/17 at 9:39 Coordinator indicated the chewing or swallowing quired no thickened dent had been assessed is nutritional needs.  cord was reviewed on c.m. The physician's nee 2017, indicated the sees included, but were neephalopathy, and psychotic disorder.  Imission nursing d 1/16/17, indicated the ependent with eating and or swallowing problems.  Attritional assessment, adicated the resident had wallowing problems and diet with diet beverages						

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

Event ID:

VKEC11

Facility ID: 000446

If continuation sheet

Page 19 of 77

PRINTED: 07/26/2017 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155511		A. BUILDING B. WING	00	COM	TE SURVEY  SPLETED  13/2017	
	PROVIDER OR SUPPLIER	AND REHABILITATION CENTER	830 S 6	ADDRESS, CITY, STATE, ZIP STH ST HAUTE, IN 47807	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	1/23/17, indicate independent with	set) assessment, dated at the resident was an eating and had no lowing problems.				
	3/16/17, indicate independent with	ing assessment, dated and the resident was a cating and had no lowing problems.				
		on Form, dated 6/1/17, ident had an order for a				
		ident had no chewing or lems.				
	4/23/17, indicate chewing and swa Interventions inc	attritional care plan, dated at the resident had allowing problems. cluded, but were not by screens as needed and s.				
	Director of Clini a document, date "Resident Assess indicated the pol being used by th indicated, "Polic	assessment of a resident's				

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

Event ID:

VKEC11

Facility ID: 000446

If continuation sheet

Page 20 of 77

PRINTED: 07/26/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA  AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		r í	ULTIPLE CO JILDING	nstruction 00	(X3) DATE : COMPL		
ANDILAN	or correction	155511	B. WI		00	06/13/	
		100011			DDDEGG CITY OT THE ZIP COPE	00/10/	2011
NAME OF P	ROVIDER OR SUPPLIER			830 S 6	ADDRESS, CITY, STATE, ZIP CODE		
TERRE H	AUTE NURSING A	ND REHABILITATION CENTER			HAUTE, IN 47807		
(X4) ID	SUMMARY ST	FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	Interpretation and	d Implementation3.					
	The purpose of the	he assessment is to					
	describe the resid	dent's capacity to					
	perform daily life	e functions and to					
	identify significa	int impairments in					
	functional capaci	ity. 4. Information					
	derived from the	comprehensive					
	assessment enabl	les the staff to plan care					
	that allows the re	esident to reach his/her					
	highest practicab	ole level of					
	functioning"						
	3.1-31(a)						
	3.1-31(b)(2)(5)						
F 0279	483.20(d);483.21(l	b)(1) REHENSIVE CARE					
SS=D Bldg. 00	PLANS	REHENSIVE CARE					
Diag. 00	483.20						
		must maintain all resident					
		pleted within the previous					
		esident's active record softhe assessments to					
		nd revise the resident's					
	comprehensive ca						
	483.21						
	(b) Comprehensive	e Care Plans					
	· · ·	st develop and implement					
	a comprehensive properties for each resident,	person-centered care plan					
		forth at §483.10(c)(2) and					
	_	t includes measurable					
	objectives and time	eframes to meet a					
		, nursing, and mental and					
	psychosocial need	Is that are identified in the					

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

Event ID:

VKEC11 Facility ID: 000446

If continuation sheet

Page 21 of 77

PRINTED: 07/26/2017 FORM APPROVED OMB NO. 0938-0391

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155511	,	ILDING	NSTRUCTION  00	(X3) DATE : COMPL <b>06/13</b> /	ETED
	PROVIDER OR SUPPLIER	AND REHABILITATION CENTER		830 S 6	DDRESS, CITY, STATE, ZIP CODE ΓΗ ST HAUTE, IN 47807		
(X4) ID PREFIX	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL	I	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	(X5) COMPLETION
TAG	comprehensive as	seessment. The are plan must describe the		TAG	DEFICIENCY)		DATE
	attain or maintain practicable physic	-being as required under					
	required under §4 but are not provide	nat would otherwise be 83.24, §483.25 or §483.40 ed due to the resident's under §483.10, including treatment under					
	rehabilitative servi provide as a resul recommendations the findings of the	ed services or specialized ices the nursing facility will t of PASARR if a facility disagrees with PASARR, it must indicate resident's medical record.					
	(iv)In consultation resident's represe	with the resident and the entative (s)-					
	(A) The resident's desired outcomes	goals for admission and					
	for future discharg document whethe return to the commonly referrals to loo	preference and potential ge. Facilities must r the resident's desire to munity was assessed and cal contact agencies opriate entities, for this					
	care plan, as appr	ns in the comprehensive ropriate, in accordance ents set forth in paragraph					

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

Event ID:

VKEC11 Facility ID: 000446

If continuation sheet

Page 22 of 77

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPLETED	
		155511	B. WI	NG		06/13/2017	
				STREET /	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER	R		830 S 6			
TERRE I	HALITE NUIRSING A	AND REHABILITATION CENTER			HAUTE, IN 47807		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG		DATE	
			F 02	279	F279	07/13/2017	
	Based on observ	ration, interview, and			400 004 1) 400 004 1/4 105 /5/ 00		
	record review, the facility failed to develop a care plan for a resident who				483.20(d);483.20(b)(1)DEVELOP		
					COMPREHENSIVE CARE PLANS		
	had a significant	weight loss (Resident			A facility must maintain all residen		
	_	nt who self-administered			assessments completed within the		
	1	ident 7) for 2 of 16			previous 15 months in the		
	,	<i>'</i>			resident's active record and use the	e	
	residents review	ed for care plans.			results of the assessment to		
					develop, review, and revise the		
	Findings include	): :			resident's comprehensive care plar	ı <b>.</b>	
	1. Resident 2's re	ecord was reviewed on			1. How will the corrective action b	e	
	6/9/17 at 11:45 a	a.m. An admission			accomplished for those residents		
	record, dated 4/1	19/17, included but was			who are affected by this alleged		
	· ·	agnoses of type 2			deficient practice?		
		complications, edema,					
		-			Resident #2 care plan was amended		
	_	pellar ataxia (brain			for a significant weight loss.		
	1	cified dementia without			Resident #7 re-educated on placing		
	behavioral distu	·			nebulizer tubing and mouth piece		
	gastro-esophage	al reflux disease without			into a plastic bag; resident refuses t	0	
	esophagitis				place items in bag. After resident		
					does breathing treatment, nursing		
	Resident 2's wei	ght history indicated:			will clean /dry out medication		
	·	5			cup of the mouth piece, place the		
	a. 1/1/17: 230 pc	ounds			tubing, mouth piece into a bag		
	u. 1/1/17. 250 pc	funds.			labeled with resident's name and		
	1. 2/4/17. 210.1	1			place in med cart.		
	b. 2/4/17: 218.1	pounds					
					All updated care plans will be placed	1	
	c. 4/10/17: 218.9	pounds			in the active Care Plan binder for		
					Nurse's to access.		
	d: 4/11/17: 219.	7 pounds			2. How will the facility identify		
					resident having the potential to be		
	e: 4/12/17: 219 p	oounds			affected by the same deficient		
					practice?		

PRINTED: 07/26/2017 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 00 COMPLETED 155511 B. WING 06/13/2017 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 830 S 6TH ST TERRE HAUTE NURSING AND REHABILITATION CENTER TERRE HAUTE, IN 47807 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG  $\mathsf{TAG}$ f: 5/6/17: 209.6 pounds -All residents in the facility could potentially be affected by this g. Undated, first week of June 2017: 206 practice. Care plans must be pounds. developed for any resident that has had a significant weight loss/gain; if A dietary progress note, dated 2/21/17, resident expresses the desire to lose included, but was not limited to, resident weight, the resident's care plan must reflect those wishes. All had a significant weight loss of 5.1 resident care plans were reviewed to percent in 30 days. Resident indicated he ensure all active care plans are wanted to lose weight and was happy available in the active care plan with the weight loss. No new binder. Corrections were made recommendations were made. where needed. 3. What measures were put into An annual minimum data set (MDS) place or systemic changes made to assessment, dated 3/23/17, indicated ensure that the deficient practice Resident 2 was cognitively intact. not recur? -On 6/26/17 all nursing staff were A nutrition assessment, dated 4/18/17, in-serviced regarding proper care included, but was not limited to, resident and storage of nebulizer equipment would maintain current body weight with no significant changes, and would -MDS will monitor any continue with current plan of care and changes that may need to be monitor completed on resident care plans. -MDS will perform random audits A care plan, created on 2/2/15, and last ensuring resident's care plans are revised on 5/18/17, included, but was not included in the active Care Plan limited to, a focus of resident had the binder for Nurses to access. potential for nutritional problem related to diagnosis of diabetes mellitus, 4. How will the facility monitor its corrective action? dementia, and cerebellar ataxia. The goal was resident to maintain adequate

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

nutritional status as evidenced by

the baseline weight. Interventions

maintaining a weight within 5 percent of

Event ID:

VKEC11

Facility ID: 000446

If continuation sheet

-To ensure compliance, the MDSC

will be responsible for monitoring

DON/Designee will be responsible

care plans for accuracy. The

Page 24 of 77

PRINTED: 07/26/2017 FORM APPROVED OMB NO. 0938-0391

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155511	ì í	ILDING	nstruction 00	(X3) DATE : COMPL <b>06/13</b> /	ETED
	PROVIDER OR SUPPLIER	ND REHABILITATION CENTER		830 S 6	NDDRESS, CITY, STATE, ZIP CODE TH ST HAUTE, IN 47807		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	needed a calm, q time, administer ordered, provide ordered, and reg and made diet chas needed. There plan for resident lose weight.  During an interval. Resident 2 to lose weight and 170 pounds.  2. On 6/7/17 at 1 was in his room treatment, when turned the maching placed tubing and bedside table, and On 6/9/17 at 8:5' nebulizer tubing observed on bed inside of bag.  On 6/9/17 at 2:0' nebulizer tubing observed on bed inside of bag.  On 6/12/17 at 11	re not limited to, resident quiet environment at meal ed medications as d and served diet as istered dietitian evaluated range recommendations e was no indication of a sexpressed desire to iew on 6/13/17 at 8:28 indicated he would like ad had a goal weight of 1:26 a.m., Resident 7 giving self a breathing completed the resident ne off per self and d mouthpiece onto d did not place in bag.  7 a.m., Resident 7's and mouth piece were side table, not placed  8 p.m., Resident 7's and mouth piece were side table, not placed			for monitoring the proper cleaning and storage of nebulizer equipment QAPI audits weekly for four weeks and monthly for six months thereafter until compliance is maintained for two consecutive quarters. The results of the 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 regional operations staff and corporate risk management for review.  Date Completed: July 3, 2017		
1	nebulizer tubing	and mouth piece were					

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

Event ID:

VKEC11

Facility ID: 000446

If continuation sheet

Page 25 of 77

PRINTED: 07/26/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA  AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		ľ í	IULTIPLE CO UILDING	NSTRUCTION 00	COMPL		
		155511	B. W		00	06/13/	
	PROVIDER OR SUPPLIEF	L AND REHABILITATION CENTER	<u> </u>	830 S 6	DDRESS, CITY, STATE, ZIP CODE TH ST HAUTE, IN 47807		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
	inside of bag.	side table, not placed					
	nebulizer tubing	21 a.m., Resident 7's and mouth piece were side table, not placed					
	6/8/17 at 1:24 p. care plan include	ord was reviewed on m. The diagnosis on the ed, but was not limited to Obstructive Pulmonary ergies.					
	but was not limit budesonide (ster 0.25 mg (milligr suspension inhal nebulizer (device medication in the	sicians orders included, ted to, start date 9/29/16 oid and decongestant) ams)/ 2 ml (milliliters) e 2 ml (milliliters) via e used to deliver e form of a mist) 2 times rinse mouth and spit.					
	physician's order included, but wa	original comprehensive r sheet, dated 3/19/17, s not limited to, resident nebulizer treatments to					
	plan obtained from plan book with a was provided by	07 p.m., a copy of a care om the nurses station care a revision date of 9/14/16 the MDS (Minimum nator and included, but					

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

Event ID:

VKEC11

Facility ID: 000446

If continuation sheet

Page 26 of 77

PRINTED: 07/26/2017 FORM APPROVED OMB NO. 0938-0391

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155511		ILDING	nstruction <u>00</u>	(X3) DATE COMPL 06/13/	ETED
		ND REHABILITATION CENTER		830 S 6	DDRESS, CITY, STATE, ZIP CODE TH ST HAUTE, IN 47807		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	]	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	has potential for and has allergies revision date of 2 was not limited to ordered, monitor effects and effect other care plans the self-administ the resident's con at this time"  During an intervipum., Resident 7 administered his when finished pumouthpiece on hindicated he did back into bag bettrouble and that be equipment after the did back into bag bettrouble and that be equipment after the did back into bag bettrouble and that be equipment after the did back into bag bettrouble and that be equipment after the did back into bag bettrouble and that be equipment after the did back into bag bettrouble and that be equipment after the did back into bag bettrouble and that be equipment after the did back into the bag back into the ba	breathing treatments and ats his tubing and is bedside table, not place the mouthpiece cause it was too much he did not clean the each use.  Siew on 6/9/17 at 2:08 Director of Nursing) Ident cleaned the hent after use and should biece in the bag once the ent was completed. Also NA's (Certified Nursing d place the mouthpiece if the resident did not.					
	_	iew on 6/13/17 at 9:32 adicated there was an					

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

Event ID:

VKEC11 Facility ID: 000446

If continuation sheet

Page 27 of 77

PRINTED: 07/26/2017 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER:	r í	IULTIPLE CO UILDING	NSTRUCTION 00	(X3) DATE COMPL	
		155511	B. W		<u>oo                                   </u>	06/13/	
				STREET A	DDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER				830 S 6			
TERRE H	HAUTE NURSING A	AND REHABILITATION CENTER		TERRE	HAUTE, IN 47807		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		n hand written in for					
		on and was found in the					
	MDS files locate	ed in the MDS office.					
	During an interv	riew on 6/13/17 at 9:40					
	_	oordinator indicated that					
		vere kept in the MDS					
	_	odated self-administration					
	care plan was pla						
		e updated care plans					
		l in the active care plan					
	_	es' station for the nurses					
	to have access to						
	to nave access to	··					
	On 6/12/17 at 12	2:54 p.m., the Regional					
		ical Operations provided					
		d, "Using the Care Plan,"					
		e policy was the one					
	currently being u	used by the facility. The					
	policy indicated,	, "Policy Statement: The					
	care plan shall b	e used in developing the					
	resident's daily o	eare routines and will be					
	available to staff	f personnel who have					
	responsibility fo	r providing care or					
	services to the re	esident. Policy					
	_	d Implementation: 1.					
	_	plans are placed in the					
		and/or in a 3-ring binder					
	_	propriate nurses' station.					
		e resident's condition					
		l to the MDS assessment					
		nat a review of the					
		ment and care plan can					
	be made. 6. Doc	umentation must be					

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

Event ID:

VKEC11

Facility ID: 000446

If continuation sheet

Page 28 of 77

PRINTED: 07/26/2017 FORM APPROVED OMB NO. 0938-0391

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPI				
		155511	B. WII	NG		06/13/	2017
NAME OF PROVIDER OR SUPPLIER  TERRE HAUTE NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE  830 S 6TH ST TERRE HAUTE, IN 47807				
(X4) ID PREFIX	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES  CY MUST BE PRECEDED BY FULL  LOG DESTRESANCE DEFORMATIONS		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	Ē	(X5) COMPLETION
(X4) ID	SUMMARY ST (EACH DEFICIENCE REGULATORY OR Consistent with the On 6/12/17 at 1:10 (Director of Nurse document titled, Medication," and was the one currely facility. The poling "Documentation self-administration resident's compression of the services proving the services proving facility, as outlined care plan, musticated on observer record review, the lab work as order 2 residents (Resident 4), provindicated on the facility of the services on one activity fluid intake as in (Resident 4), provindicated on the facility of the services on the services of the services on the services of the services on the services of the services on the services of the servi	ratement of deficiencies CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) The resident's care plan"  12 p.m., the DON Sing) provided a "Self-Administration of d indicated the policy tently being used by the cy indicated, on:2. Document the on of medication on the tehensive plan of care"  JALIFIED PERSONS/PER sive Care Plans ded or arranged by the l by the comprehensive  qualified persons in ach resident's written plan ation, interview, and the facility failed to obtain ared by the physician for dent 4 and 7), provide ity visits to encourage dicated on the care plan vide nail care as care plan (Resident 12),	F 02	ID PREFIX TAG	F282  483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN  Comprehensive Care Plans The services provided by the facility as outlined by the comprehensive care.		` ´
	indicated on the and to notify the	care plan (Resident 12), physician for an nent of a resident			outlined by the comprehensive care plan must-be provided by qualified persons in accordance with each resident's written plan of care.	•	

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

Event ID:

VKEC11

Facility ID: 000446

If continuation sheet

Page 29 of 77

A BUILDING 155511  NAME OF PROVIDER OR SUPPLIER TERRE HAUTE NURSING AND REHABILITATION CENTER  (X4) ID PREFIX TAG  REGULATORY OR LSC IDENTIFYING INFORMATION)  1. Resident 4's record was reviewed on 6/8/17 at 1:24 p.m. An admission record, dated 4/19/17, included, but was not limited to, diagnoses of paranoid schizophrenia, major depressive disorder, type II diabetes mellitus without complications, hypothyroidism, edema, and unspecified convulsions.  A physician's order, dated 8/9/16, included, but was not limited to, dilantin level (a seizure medication) and thyroid stimulating hormone (TSH) every 6	STATEMEN	NT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPL		ULTIPLE CO	CONSTRUCTION		(X3) DATE SURVEY	
NAME OF PROVIDER OR SUPPLIER  TERRE HAUTE NURSING AND REHABILITATION CENTER  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  Treviewed for care plans.  Findings include:  1. Resident 4's record was reviewed on 6/8/17 at 1:24 p.m. An admission record, dated 4/19/17, included, but was not limited to, diagnoses of paranoid schizophrenia, major depressive disorder, type II diabetes mellitus without complications, hypothyroidism, edema, and unspecified convulsions.  A physician's order, dated 8/9/16, included, but was not limited to, dilantin level (a seizure medication) and thyroid stimulating hormone (TSH) every 6	AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
TERRE HAUTE NURSING AND REHABILITATION CENTER  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Teviewed for care plans.  Findings include:  1. Resident 4's record was reviewed on 6/8/17 at 1:24 p.m. An admission record, dated 4/19/17, included, but was not limited to, diagnoses of paranoid schizophrenia, major depressive disorder, type II diabetes mellitus without complications, hypothyroidism, edema, and unspecified convulsions.  A physician's order, dated 8/9/16, included, but was not limited to, diantin level (a seizure medication) and thyroid stimulating hormone (TSH) every 6			155511	B. WI	ING		06/13/2017	
TERRE HAUTE NURSING AND REHABILITATION CENTER  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Teviewed for care plans.  Findings include:  1. Resident 4's record was reviewed on 6/8/17 at 1:24 p.m. An admission record, dated 4/19/17, included, but was not limited to, diagnoses of paranoid schizophrenia, major depressive disorder, type II diabetes mellitus without complications, hypothyroidism, edema, and unspecified convulsions.  A physician's order, dated 8/9/16, included, but was not limited to, diantin level (a seizure medication) and thyroid stimulating hormone (TSH) every 6  Bas S 6TH ST TERRE HAUTE, IN 47807  ID PROVIDERS PLAN OF CORRECTION (X5)  COMPLETION CROSS REFERENCE TO THE APPROPRIATE COMPLETION (DATE)  PREFIX TAG  PREVIDERS PLAN OF CORRECTION (X5)  COMPLETION (CSS)  COMPLETION CROSS REFERENCE COMPLETION (DATE)  Low will the corrective action be accomplished for those residents who are affected by this alleged deficient practice?  -Labs were obtained for Resident #7 for a Lipid profile, Hepatic Profile and TSH 6/29/17  -Resident #12 received nail care per Nail Care policy  -Resident #12 received nail care per Nail Care policy  -Resident #12 received nail care per Nail Care policy  -Resident #19 physician was notified of AIMS results.				STREET ADDRESS CITY STATE 7ID CODE				
TERRE HAUTE NURSING AND REHABILITATION CENTER  (X4) ID PREFIX TAG  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  FEVI EN GENERAL OR COMPLETION (EACH DEFICIENCY)  REGULATORY OR LSC IDENTIFYING INFORMATION)  Teviewed for care plans.  Findings include:  1. Resident 4's record was reviewed on 6/8/17 at 1:24 p.m. An admission record, dated 4/19/17, included, but was not limited to, diagnoses of paranoid schizophrenia, major depressive disorder, type II diabetes mellitus without complications, hypothyroidism, edema, and unspecified convulsions.  A physician's order, dated 8/9/16, included, but was not limited to, dilantin level (a seizure medication) and thyroid stimulating hormone (TSH) every 6  ID PREFIX PROVIDERS PLAN OF CORRECTION (X5) COMPLETION PREFIX TAG  PREFIX TAG  PREFIX TAG  PREFIX TAG  PREFIX TAG  PROVIDERS PLAN OF CORRECTION (ISA) COMPLETION DATE   1. How will the corrective action be accomplished for Resident who are affected by this alleged deficient practice?  -Labs were obtained for Resident 44for a Dilantin Level, TSH and Hgba1C on 6/29/17 and was added to 1:1 activity for fluids.  -Labs were obtained for Resident #7 for a Lipid profile, Hepatic Profile and TSH 6/29/17  -Resident #12 received nail care per Nail Care policy  Nail Care policy  -Resident #9 physician was notified of AIMS results.	NAME OF F	PROVIDER OR SUPPLIEF	₹					
SUMMARY STATEMENT OF DEFICIENCIES   ID   PROVIDERS PLAN OF CORRECTION   COMPLETION   DATE	TEDDE I	ANTITE NITIDSING /	AND DEHARII ITATION CENTED					
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  PREFIX TAG  PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION)  PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION)  PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION)  1. How will the corrective action be accomplished for those residents who are affected by this alleged deficient practice?  1. Resident 4's record was reviewed on 6/8/17 at 1:24 p.m. An admission record, dated 4/19/17, included, but was not limited to, diagnoses of paranoid schizophrenia, major depressive disorder, type II diabetes mellitus without complications, hypothyroidism, edema, and unspecified convulsions.  A physician's order, dated 8/9/16, included, but was not limited to, dilantin level (a seizure medication) and thyroid stimulating hormone (TSH) every 6			AND REHABIEITATION CENTER		ILIXIXL	11A01E, IN 47607		
TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY D						PROVIDER'S PLAN OF CORRECTION		· ·
reviewed for care plans.  Findings include:  1. Resident 4's record was reviewed on 6/8/17 at 1:24 p.m. An admission record, dated 4/19/17, included, but was not limited to, diagnoses of paranoid schizophrenia, major depressive disorder, type II diabetes mellitus without complications, hypothyroidism, edema, and unspecified convulsions.  A physician's order, dated 8/9/16, included, but was not limited to, dilantin level (a seizure medication) and thyroid stimulating hormone (TSH) every 6		`				CROSS-REFERENCED TO THE APPROPRIA	TE	
Findings include:  1. Resident 4's record was reviewed on 6/8/17 at 1:24 p.m. An admission record, dated 4/19/17, included, but was not limited to, diagnoses of paranoid schizophrenia, major depressive disorder, type II diabetes mellitus without complications, hypothyroidism, edema, and unspecified convulsions.  A physician's order, dated 8/9/16, included, but was not limited to, dilantin level (a seizure medication) and thyroid stimulating hormone (TSH) every 6  Labs were obtained for Resident #4 #4for a Dilantin Level, TSH and HgbA1C on 6/29/17 and was added to 1:1 activity for fluids.  Labs were obtained for Resident #7 for a Lipid profile, Hepatic Profile and TSH 6/29/17  -Resident #12 received nail care per Nail Care policy  -Resident #9 physician was notified of AIMS results.	TAG		, , , , , , , , , , , , , , , , , , ,		TAG			DATE
Findings include:  1. Resident 4's record was reviewed on 6/8/17 at 1:24 p.m. An admission record, dated 4/19/17, included, but was not limited to, diagnoses of paranoid schizophrenia, major depressive disorder, type II diabetes mellitus without complications, hypothyroidism, edema, and unspecified convulsions.  A physician's order, dated 8/9/16, included, but was not limited to, dilantin level (a seizure medication) and thyroid stimulating hormone (TSH) every 6  who are affected by this alleged deficient practice?  -Labs were obtained for Resident #16/29/17 and was added to 1:1 activity for fluids.  -Labs were obtained for Resident #7 for a Lipid profile, Hepatic Profile and TSH 6/29/17  -Resident #12 received nail care per Nail Care policy  -Resident #9 physician was notified of AIMS results.		reviewed for car	e plans.				e	
deficient practice?  1. Resident 4's record was reviewed on 6/8/17 at 1:24 p.m. An admission record, dated 4/19/17, included, but was not limited to, diagnoses of paranoid schizophrenia, major depressive disorder, type II diabetes mellitus without complications, hypothyroidism, edema, and unspecified convulsions.  A physician's order, dated 8/9/16, included, but was not limited to, dilantin level (a seizure medication) and thyroid stimulating hormone (TSH) every 6  deficient practice?  -Labs were obtained for Resident #4 #4for a Dilantin cyllantin deficient practice?  -Labs were obtained for Resident #7 for a Lipid profile, Hepatic Profile and TSH 6/29/17  -Resident #12 received nail care per Nail Care policy  -Resident #9 physician was notified of AIMS results.						<u>-</u>		
1. Resident 4's record was reviewed on 6/8/17 at 1:24 p.m. An admission record, dated 4/19/17, included, but was not limited to, diagnoses of paranoid schizophrenia, major depressive disorder, type II diabetes mellitus without complications, hypothyroidism, edema, and unspecified convulsions.  A physician's order, dated 8/9/16, included, but was not limited to, dilantin level (a seizure medication) and thyroid stimulating hormone (TSH) every 6		Findings include	<del>:</del>					
6/8/17 at 1:24 p.m. An admission record, dated 4/19/17, included, but was not limited to, diagnoses of paranoid schizophrenia, major depressive disorder, type II diabetes mellitus without complications, hypothyroidism, edema, and unspecified convulsions.  A physician's order, dated 8/9/16, included, but was not limited to, dilantin level (a seizure medication) and thyroid stimulating hormone (TSH) every 6  #4for a Dilantin Level, TSH and HgbA1C on 6/29/17 and was added to 1:1 activity for fluids.  -Labs were obtained for Resident #7 for a Lipid profile, Hepatic Profile and TSH 6/29/17  -Resident #12 received nail care per Nail Care policy  -Resident #9 physician was notified of AIMS results.						deficient practice?		
dated 4/19/17, included, but was not limited to, diagnoses of paranoid schizophrenia, major depressive disorder, type II diabetes mellitus without complications, hypothyroidism, edema, and unspecified convulsions.  A physician's order, dated 8/9/16, included, but was not limited to, dilantin level (a seizure medication) and thyroid stimulating hormone (TSH) every 6  HgbA1C on 6/29/17 and was added to 1:1 activity for fluids.  -Labs were obtained for Resident #7 for a Lipid profile, Hepatic Profile and TSH 6/29/17  -Resident #12 received nail care per Nail Care policy  -Resident #9 physician was notified of AIMS results.		1. Resident 4's re	ecord was reviewed on			-Labs were obtained for Resident		
dated 4/19/17, included, but was not limited to, diagnoses of paranoid schizophrenia, major depressive disorder, type II diabetes mellitus without complications, hypothyroidism, edema, and unspecified convulsions.  A physician's order, dated 8/9/16, included, but was not limited to, dilantin level (a seizure medication) and thyroid stimulating hormone (TSH) every 6  HgbA1C on 6/29/17 and was added to 1:1 activity for fluids.  -Labs were obtained for Resident #7 for a Lipid profile, Hepatic Profile and TSH 6/29/17  -Resident #12 received nail care per Nail Care policy  -Resident #9 physician was notified of AIMS results.		6/8/17 at 1:24 p.	m. An admission record,			#4for a Dilantin Level, TSH and		
limited to, diagnoses of paranoid schizophrenia, major depressive disorder, type II diabetes mellitus without complications, hypothyroidism, edema, and unspecified convulsions.  A physician's order, dated 8/9/16, included, but was not limited to, dilantin level (a seizure medication) and thyroid stimulating hormone (TSH) every 6  to 1:1 activity for fluids.  -Labs were obtained for Resident #7 for a Lipid profile, Hepatic Profile and TSH 6/29/17  -Resident #12 received nail care per Nail Care policy  -Resident #9 physician was notified of AIMS results.		dated 4/19/17, ir	ncluded, but was not			HgbA1C on 6/29/17 and was added		
schizophrenia, major depressive disorder, type II diabetes mellitus without complications, hypothyroidism, edema, and unspecified convulsions.  A physician's order, dated 8/9/16, included, but was not limited to, dilantin level (a seizure medication) and thyroid stimulating hormone (TSH) every 6		1				to 1:1 activity for fluids.		
type II diabetes mellitus without complications, hypothyroidism, edema, and unspecified convulsions.  A physician's order, dated 8/9/16, included, but was not limited to, dilantin level (a seizure medication) and thyroid stimulating hormone (TSH) every 6			*					
complications, hypothyroidism, edema, and unspecified convulsions.  A physician's order, dated 8/9/16, included, but was not limited to, dilantin level (a seizure medication) and thyroid stimulating hormone (TSH) every 6		_					'	
and unspecified convulsions.  A physician's order, dated 8/9/16, included, but was not limited to, dilantin level (a seizure medication) and thyroid stimulating hormone (TSH) every 6								
A physician's order, dated 8/9/16, included, but was not limited to, dilantin level (a seizure medication) and thyroid stimulating hormone (TSH) every 6  -Resident #12 received nail care per Nail Care policy  -Resident #9 physician was notified of AIMS results.		_				and 15H 6/29/17		
A physician's order, dated 8/9/16, included, but was not limited to, dilantin level (a seizure medication) and thyroid stimulating hormone (TSH) every 6  Nail Care policy  -Resident #9 physician was notified of AIMS results.		and unspecified	convuisions.			-Resident #12 received nail care ne	r	
included, but was not limited to, dilantin level (a seizure medication) and thyroid stimulating hormone (TSH) every 6			1 1 1 1 0 10 /1 6			·		
level (a seizure medication) and thyroid stimulating hormone (TSH) every 6						, ,		
stimulating hormone (TSH) every 6		1	·			-Resident #9 physician was notified		
		,	, ·			of AIMS results.		
		stimulating horn	none (TSH) every 6					
month in March and September.		month in March	and September.			2. How will the facility identify		
residents having the potential to be						= -	9	
A physician's order, dated 8/9/16,		A physician's or	der, dated 8/9/16,			<u>-</u>		
included, but was not limited to HgbA1C						practice?		
(blood test related to diabetes mellitus)  -All residents could potentially be		1	•			-All residents could potentially be		
every 3 months (September, December,  affected by this practice, However,		,	,			•		
March, and June).		1				due to the implementation of the		
Lab Monitoring Form and double		iviaicii, and sunc	/)·			Lab Monitoring Form and double		
checking the monthly re-writes for			S 11 ( 4) 11 1			checking the monthly re-writes for		
A review of all Resident 4's lab work upcoming labs this alleged practice						upcoming labs this alleged practice		
from January 2017 to June 2017 did not will not recur. All resident's chart		1				will not recur. All resident's chart		
include any documentation of a dilantin were audited to ensure nothing else		include any docu	umentation of a dilantin			were audited to ensure nothing else	:	
level, TSH, or HgbA1C being done or has been missed, any missed lab was		level, TSH, or H	gbA1C being done or			· •	S	
refused. ordered to be done.		refused.				ordered to be done.		
- DON will monitor resident showers						- DON will monitor resident shower		
A care plan, initiated 7/21/16, and last  Sheets and Point, Click, Care for nail		A care plan, init	iated 7/21/16, and last					
revised on 5/15/17, indicated a focus of care completion documentation and		1 * *	· · · · · · · · · · · · · · · · · · ·					
Resident 4 has a potential for abnormal will conduct random audits of						· ·	-	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		00	COMPLETED	
		155511	B. WING 06/13/		2017		
NAME OF I	DROVIDED OD GLIDDLIEF			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEF	C		830 S 6	STH ST		
TERRE H	HAUTE NURSING A	AND REHABILITATION CENTER		TERRE	HAUTE, IN 47807		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG			DATE
		eizure disorder, diabetes			regarding nail care.		
	mellitus, and hyp	•			-DON/Dietary Manager will conduc	+	
		cluded, but were not			random audits during meal service		
	limited to, labs/t	ests as per physician's			times to ensure adequate fluid		
	order and notifie	ed physician of all lab/test			options are offered to each residen	t.	
	results.						
					-A review was made of all resident'	S	
	During an interv	riew on 6/9/17 at 11:24			AIMS results to ensure physician wa	as	
	a.m., the Directo	or of Nursing (DON)			aware if abnormal movement was		
	1	ntacted the lab to ask for			noted.		
		dilantin level, TSH, and			3. What measures were put into		
		ould have been done in			place or systemic changes made to	,	
	"	ne lab did not have any			ensure that the deficient practice		
		of 2017. Dilantin level,			not recur?		
		-					
	1	1C were not done in			- On 6/26/17 all Licensed Nursing		
	March 2017.				Staff were in-serviced on "Obtainin		
					Labs as ordered by Physician" polic	у.	
		2:00 p.m., Resident 4's			- On 6/26/17 all Nursing Staff were		
	lips were noted t	to be dry.			in-serviced on "Nail Care" Policy,		
					Nail care is to be completed on		
	On 6/7/17 at 2:0	8 p.m., Resident 4 was			shower days and as needed.		
	observed to be e	ating lunch in her room,					
	no drinks were p	provided for lunch.			-On 6/26/17 all Nursing and Dietary		
					staff were in-serviced on offering 2	-3	
	On 6/8/17 at 2:4	6 p.m., Resident 4's			fluid options with each meal with		
		room was observed to be			Hydration Cart being accessible to Staff and Residents 24/7.		
		ll with no ice. No straw			Stail allu nesiuellis 24/1.		
		erved in Resident 4's			- On 6/26/17 all Nursing Staff were		
	room. Lips were				in-serviced on passing fresh ice		
	100m. Lips were	·			water each shift.		
		31 a.m., Resident 4 was			4. How will the facility monitor its	s	
	observed to be s	itting up in the			corrective action?		
	wheelchair in he	er room, lips were dry.					
					-To ensure compliance.		

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

Event ID:

VKEC11 Facility ID: 000446

If continuation sheet Page 31 of 77

STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA				(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPLETED
		155511	B. W	B. WING		06/13/2017
				STREET A	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIER			830 S 6	TH ST	
TERRE H	HAUTE NURSING A	AND REHABILITATION CENTER			HAUTE, IN 47807	
(X4) ID	STIMMADV S	TATEMENT OF DEFICIENCIES	I	ID		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	* /
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	DATE
		lunch observation on			DON/designee is responsible for the	
	_				completion of the monitoring of	
	_	o.m., Resident 4 was			physician order for all lab testing,	
		h 8 ounces of coffee. No			monitoring residents shower sheets	
		re offered. Staff was not			and Point, Click, Care for nail care	
	observed to enco	ourage Resident 4 to			completion. QAPI audits weekly for	
	drink her fluids.				four weeks and monthly for six	
					months thereafter until compliance	
	On 6/9/17 at 12:	31 p.m., Resident 4			is maintained for two consecutive	
		ade to go with lunch.			quarters. Dietary Manager/DON are	
		erved as requested.			responsible for ensuring resident	
	Lemonade was s	crved as requested.			have adequate fluid options	
					available during meal service QAPI	
		iew on 6/9/17 at 10:12			audits weekly for four weeks and	
	a.m., the Directo	r of Nursing (DON)			monthly for six months thereafter	
	indicated fluids	were documented in the			until compliance is maintained for	
	Certified Nursing	g Assistant's (CNA)			two consecutive quarters. Dietary	
	computer charting	ng only. Fluids were not			Manager/Dietary Staff are	
	•	where else in the record.			responsible for ensuring hydration	
	1	ydration concerns that			cart is adequately stocked for use after kitchen closes for the evening.	
	·	inicated to the DON.			QAPI audits weekly for four weeks	
	nau been commit	inicated to the DON.			and monthly for six months	
	- · · · · · · ·				thereafter until compliance is	
		ord was reviewed on			maintained for two consecutive	
	_	m. A admission record,			quarters. The results of the audits	
	dated 4/19/17, in	cluded, but was not			will be reviewed by the QAPI	
	limited to, paran	oid schizophrenia, major			committee monthly. If 95%	
	depressive disord	der, type II diabetes			compliance is not achieved, an	
	_	complications, edema,			action plan will be developed and	
		nageal reflux disease			implemented. Monthly QAPI	
	without esophag				minutes and action plans are	
	without esophag	10.			submitted to regional operations	
	A				staff and corporate risk	
		sment, dated 2/4/17,			management for review.	
	ĺ .	s not limited to, a fluid			Data Completed: Like 3 2017	
	need of 2925 mi	lliliters (ml) daily.			Date Completed: July 3,2017	
	Average fluid co	nsumption with meals				
	was 480-600 ml.					
	i		1			1

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

Event ID:

VKEC11

Facility ID: 000446

If continuation sheet

Page 32 of 77

PRINTED: 07/26/2017 FORM APPROVED OMB NO. 0938-0391

	of correction identification number:  155511	A. BUILDING B. WING	00	COMPLETED  06/13/2017
	PROVIDER OR SUPPLIER HAUTE NURSING AND REHABILITATION CENTER	830 S 6	ADDRESS, CITY, STATE, ZIP CODE STH ST HAUTE, IN 47807	
(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 APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	A review of Resident 4's daily fluid consumption indicated the following:			
	a. 5/28/17: No fluid consumption or refusal was documented.			
	b. 5/29/17-6/2/17: Resident 4 was out of the facility to the hospital.			
	c. 6/3/17: Resident 4 returned from the hospital and consumed 480 ml of fluids the remainder of the day.			
	d. 6/4/17: 960 ml.			
	e. 6/5/17: 1200 ml.			
	f. 6/6/17: 960 ml.			
	g. 6/7/17: 480 ml.			
	h. 6/8/17: 1180 ml			
	A care plan, initiated on 9/23/15, and last revised on 5/15/17, included, but was not limited to, a focus of resident had the potential for fluid deficit and dehydration. A goal, included, but was not limited to, resident will be free from symptoms of dehydration and will maintain moist mucous membranes. Interventions included, but were not limited to, invite resident to activities that			

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

Event ID:

VKEC11

Facility ID: 000446

If continuation sheet

Page 33 of 77

PRINTED: 07/26/2017 FORM APPROVED OMB NO. 0938-0391

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155511		ILDING	nstruction <u>00</u>	(X3) DATE COMPL <b>06/13</b> /	ETED
NAME OF PROVIDER OR SUPPLIER TERRE HAUTE NURSING AND REHABILITATION CENTER				830 S 6	DDRESS, CITY, STATE, ZIP CODE TH ST HAUTE, IN 47807		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	]	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	promote addition drinks during on	nal fluid intake, offer e on one visits.					
	a.m., the Activit Resident 4 is not one activity visit have any special	riew on 6/9/17 at 10:38  y Director indicated t on the list for one on ts. Resident 4 did not activity needs. Resident d anything special during ng fluids.					
	a.m., the Director indicated the Acresidents to see in needed and update accordingly. Or discussed during during care plant 3. On 6/7/19 at 2	2:06 p.m., Resident 12 ith long fingernails and					
	observed with lo	25 p.m., Resident 12 was ong fingernails and dark m, the left thumb nail					
	observed with lo	7 p.m., Resident 12 was ong fingernails and dark m, the left thumb nail					
	On 6/12/17 at 9:	33 a.m., Resident 12 was					

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

Event ID:

VKEC11 Facility ID: 000446

If continuation sheet

Page 34 of 77

PRINTED: 07/26/2017 FORM APPROVED OMB NO. 0938-0391

				NSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		A. BUILDING 00		COMPLETED	
		155511	B. WI	ING		06/13/	/2017
NAME OF F	PROVIDER OR SUPPLIER	•	_	STREET A	ADDRESS, CITY, STATE, ZIP CODE	_	
				830 S 6			
TERRE H	HAUTE NURSING A	AND REHABILITATION CENTER		TERRE	HAUTE, IN 47807		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		ong fingernails and dark					
		m, the left thumb nail					
	was cracked.						
	~	iew on 6/9/17 at 2:32					
		tified Nursing Assistant)					
		resident was totally					
	_	ail care and assist of 1					
	with bathing.						
	I -	iew on 6/9/17 at 3:07					
	_	2 indicated he did not cut					
	his own fingerna	ils.					
	~	iew on 6/12/17 at 10:26					
	l '	e CNA 12 indicated the					
	resident received	d showers daily and nail					
	care was provide	ed on shower days.					
		iew on 6/12/17 at 1:56					
		Director of Nursing)					
		were responsible for					
		il care provided to a					
	resident.						
	~	iew on 6/12/17 at 2:12					
	-	al Director of Clinical					
	_	ated there was no					
	documentation f	rom CNA's indicating					
	nail care was per	rformed for Resident 12					
	this month.						
	Resident 12's red	cord was reviewed on					
	6/9/17 at 9:02 a.i	m. Diagnosis from the					

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

Event ID:

VKEC11

Facility ID: 000446

If continuation sheet

Page 35 of 77

PRINTED: 07/26/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155511	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING	(X3) DATE SURVEY COMPLETED 06/13/2017
NAME OF PROVIDER OR SUPPLIER TERRE HAUTE NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 830 S 6TH ST TERRE HAUTE, IN 47807	E
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES  PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL  TAG REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPI DEFICIENCY)	LD BE COMPLETION
care plan included, but were not limited to, need for assistance for personal care.		
An annual MDS assessment, dated 12/17/16, indicated Resident 12 required extensive assistance of one person physical assist for personal hygiene.  A care plan initiated on 9/14/16 and revised on 2/7/17 indicated an Activities of Daily Living (ADL) self care performance deficit related to diagnosis of mild intellectual disabilities psychosis, and need of assist with dressing and grooming. Interventions included but was not limited to check nail length and trim and clean on bath day as necessary.  A review of shower sheets included, but was not limited to, Resident 12 received a shower on 6/1, 6/2, 6/3, 6/5, 6/6, 6/7, 6/8 and 6/9/17. No documentation was observed for refusal of showers for those days.		
4. Resident 7's record was reviewed on 6/8/17 at 1:24 p.m. Diagnosis from the care plan included, but were not limited to, coronary artery disease, hyperlipidemia, constipation, chronic obstructive pulmonary disease, hypertension, gerd and benign prostatic hyperplasia.		

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

Event ID:

VKEC11

Facility ID: 000446

If continuation sheet

Page 36 of 77

PRINTED: 07/26/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO A. BUILDING		(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION IDENTIFICATION NUMBER: 155511	A. BUILDING 00 COMPLETED  B. WING 06/13/2017			
	100011		ADDRESS, CITY, STATE, ZIP CODE	00/10/2017	
NAME OF I	PROVIDER OR SUPPLIER	830 S 6			
TERRE I	HAUTE NURSING AND REHABILITATION CENTER		HAUTE, IN 47807		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)	
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE COMPLETION DATE	
ing	A review of physicians orders dated	7710		BATE	
	12/14/15 included, but were not limited				
	to, labs: lipid profile, hepatic profile and				
	tsh (thyroid-stimulating hormone every 6				
	months in February and August.				
	, ,				
	A review of labs dated August of 2015				
	for lipid profile, hepatic profile and tsh,				
	there were no results provided for				
	February of 2016.				
	A review of care plans indicated, focus				
	revised on 2/24/17: resident has potential				
	for abnormal labs related to diagnosis.				
	Interventions updated 9/14/16: labs and				
	test as per medical director ordered.				
	During an interview on 6/8/17 at 2:15				
	p.m., LPN 9 indicated she phoned the				
	laboratory services used by the facility				
	and at that time they found no record for				
	a lipid profile, hepatic profile and tsh				
	drawn in February of 2016, and indicated				
	the last time these labs were drawn were				
	dated August of 2016.				
	During an interview on 6/9/17 at 8:22				
	a.m., LPN 9 indicated she followed up				
	with the facilities laboratory services and				
	there was no record the resident received				
	labs in February 2016 as ordered by				
	physician.				
	5. Resident 9's record was reviewed on				
	6/8/17 at 1:05 p.m. The physician's				

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

Event ID:

VKEC11 Facility ID: 000446

If continuation sheet Page 37 of 77

PRINTED: 07/26/2017 FORM APPROVED OMB NO. 0938-0391

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155511	(X2) MULTIPLE A. BUILDING B. WING	CONSTRUCTION  00	COM	TE SURVEY  IPLETED  13/2017
	PROVIDER OR SUPPLIEF	AND REHABILITATION CENTER	830 S	T ADDRESS, CITY, STATE, ZIP CO S 6TH ST RE HAUTE, IN 47807	DDE .	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	resident's diagnor not limited to, per depression. The medication regir limited to, quintous medication) 300 equal 500 mg, at an annual MDS assessment, date resident exhibited directed towards diagnoses that in limited to, psychologically assessment, date resident had the effects related to medications. Into were not limited that included, but EPS (extra pyrant tardive dyskines movements).  An AIMS (abnormovement scale indicated the observersion and carea of the resident movements of mexpression and carea of the resident movements of the resident movements of m	(minimum data set) d 12/9/16, indicated the d behavior symptoms others, and had active acluded, but were not otic disorder.  ed 7/12/16, indicated the potential for adverse side of the use of psychotropic erventions included, but to, monitor side effects at were not limited to, midal symptoms) and ia (involuntary body  rmal involuntary of test, dated 12/1/16, servation of involuntary sinimal muscles of facial of the lips and perioral				

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

Event ID:

VKEC11

Facility ID: 000446

If continuation sheet

Page 38 of 77

PRINTED: 07/26/2017 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		lì í	IULTIPLE CO. UILDING	NSTRUCTION 00	COMPL		
11112 12111	or condition	155511	B. W		00	06/13/	
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEF	R		830 S 6			
TERRE H	HAUTE NURSING A	AND REHABILITATION CENTER		TERRE	HAUTE, IN 47807		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	ICY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR		ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)		DATE
	the observation	ne resident's lips and					
		his face with minimal					
	_	ng, smacking and tongue					
		nd out of his mouth.					
	movements in a	nd out of ms moun.					
	A review of mer	ntal health consult notes,					
		rough 2/5/17, indicated					
	no documented	notification of the					
	resident's observ	ed involuntary abnormal					
	movements.						
		ress notes, dated					
		h 4/17/17, indicated no					
		ification of the resident's					
	observed involu	ntary abnormal					
	movements.						
	Normala Notas d	ata d 2/0/17 themas als					
	· ·	ated 3/9/17 through d no documentation of					
		cation of the resident's					
	observed involu						
	movements.	intary authorniai					
	mo vomento.						
	During an interv	riew on 6/9/17 at					
		ON (director of nursing)					
	· ·	as unsure if the physician					
		he AIMS test results for					
	December 2016	and March 2017.					
		2:54 p.m., the Regional					
		ical Operations provided					
	· ·	ised August 2006, titled,					
	"Using the Care	Plan," and indicated the					

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

Event ID:

VKEC11

Facility ID: 000446

If continuation sheet

Page 39 of 77

PRINTED: 07/26/2017 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION IDENTIFICATION NUMBER:  155511	A. BUILDING <u>00</u> B. WING		COMPLETED 06/13/2017
	PROVIDER OR SUPPLIER HAUTE NURSING AND REHABILITATION CENTER	STREET ADDRE 830 S 6TH S' TERRE HAU'		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)		PROVIDER'S PLAN OF CORRECTION EACH CORRECTIVE ACTION SHOULD BE DSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
	policy was the one currently being used by the facility. The policy indicated, "Policy Statement: The care plan shall be used in developing the resident's daily care routines and will be available to staff personnel who have responsibility for providing care or services to the resident. Policy Interpretation and Implementation:  1. Completed care plans are placed in the resident's chart and/or in a 3-ring binder located at the appropriate nurses' station.  5. Changes in the resident's condition must be reported to the MDS assessment coordinator so that a review of the resident's assessment and care plan can be made. 6. Documentation must be consistent with the resident's care plan"  On 6/12/17 at 12:54 p.m., the Regional Director of Clinical Operations provided a document titled, "Laboratory Management," and indicated the policy was the one currently being used by the facility. The policy indicated, "Overview: Residents requiring laboratory services will receive accurate and timely laboratory services so that the utilization of laboratory testing for diagnosis, treatment, prevention, or assessment is maximized. The facility is responsible for quality and timely laboratory services whether or not services are provided by the facility or an outside agency"			

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

Event ID:

VKEC11

Facility ID: 000446

If continuation sheet

Page 40 of 77

PRINTED: 07/26/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155511			(X2) MULTIPLE CONSTRUCTION       (X3) DATE SURVE         A. BUILDING       00       COMPLETED         B. WING       06/13/2017			ETED	
TERRE H		ND REHABILITATION CENTER		830 S 6	DDRESS, CITY, STATE, ZIP CODE TH ST HAUTE, IN 47807		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	F	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
F 0312 SS=D Bldg. 00	Director of Clinial a document, date "Changes in Resindicated the polloeing used by the indicated, "The notified when changes in the restaint events of Changes in the restai	s to maintain good g, and personal and oral ation, interview, and e facility failed to for 1 of 3 residents vities of daily living nt 12).  5 p.m., Resident 12 was ng fingernails and dark	F 03	12	F312  483.24(a)(2)ADL CARE PROVIDED FOR DEPENDENT RESIDENT  (a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.  1. How will the corrective action be accomplished for those residents		07/13/2017

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

Event ID:

VKEC11 Facility ID: 000446

If continuation sheet Page 41 of 77

	R MEDICARE & MEDIC				OMB NO. 0938-0391	
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED	
		155511	B. WING		06/13/2017	
NAME OF I	PROVIDER OR SUPPLIER	<u> </u>		ADDRESS, CITY, STATE, ZIP CODE		
TERRE I	HAUTE NURSING A	AND REHABILITATION CENTER		E HAUTE, IN 47807		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
	observed with lo	25 p.m., Resident 12 was ong fingernails and dark m, the left thumb nail		who are affected by this alleged deficient practice?  Resident #12 fingernails were cleaned, trimmed, and filed		
	observed with lo	7 p.m., Resident 12 was ong fingernails and dark m, the left thumb nail		2. How will the facility identify resident having the potential to be affected by the same deficient practice? All residents in the facility could potentially be affected by this.		
	On 6/12/17 at 0.	22 a.m. Davidant 12 was		potentially be affected by this practice. All residents requiring		
		33 a.m., Resident 12 was		assist with ADLs will have had their		
		ong fingernails and dark		fingernails cleaned, trimmed, and		
	debris under the	m, the left thumb nail		filed immediately and on their		
	was cracked.			respective shower day and as		
				needed.		
	During an interv	riew on 6/9/17 at 2:32		needed.		
	_	Sursing Assistant (CNA)		3. What measures were put into		
		· ,		place or systemic changes made to		
		resident was totally		ensure that the deficient practice		
	dependent for nation with bathing.	ail care and assist of 1		not recur?		
	During an interv	riew on 6/9/17 at 3:07 2 indicated he did not cut hils.		On 6/26/17 all nursing staff were in-serviced on nail care, including but not limited to trimming, filing and cleaning of resident fingernails during resident shower		
	During an interv	riew on 6/12/17 at 10:26		and as needed.		
		e CNA 12 indicated the		-Area to document nail care of the		
	-			resident shower sheets was added.		
		d a shower daily and nail		resident shower sheets was added.		
	care was provide	ed on shower days.		-Electronic documentation for		
				providing nail care was added to		
	During an interv	riew on 6/12/17 at 1:56				
	_	or of Nursing (DON)		CNA's ADL documentation on		
	•	• • •		kiosks.		
	indicated CNA's	was responsible for				

PRINTED: 07/26/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			
AND PLAN	OF CORRECTION IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLETED			
	155511	B. WING		06/13/2017	
		STDEET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER				
TEDDE L	HAUTE NURSING AND REHABILITATION CENTER	830 S 6TH ST TERRE HAUTE, IN 47807			
TERRET	HAUTE NORSING AND REHABILITATION CENTER	IERRE	HAUTE, IN 47807		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL	PREFIX (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROP		COMPLETION	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
	documenting nail care provided to a		4. How will the facility monitor its		
	resident.		corrective action?		
	During an interview on 6/12/17 at 2:12		-To ensure compliance, the DON is		
			responsible for the nail care QAPI		
	p.m., the Regional Director of Clinical		audits weekly for four weeks and		
	Operations indicated there was no		monthly for six months thereafter		
	documentation from CNA's indicating		until compliance is maintained for		
	nail care was provided this month for		two consecutive quarters. The		
Resident 12.			results of the audits will be reviewed	a	
			by the QAPI committee monthly. If		
	Resident 12's record was reviewed on		95% compliance is not achieved, an		
			action plan will be developed and		
	6/9/17 at 9:02 a.m. Diagnosis from the		implemented. Monthly QAPI		
	care plan included but was not limited to		minutes and action plans are submitted to regional operations		
	need for assistance for personal care.		staff and corporate risk		
			management for review.		
	An annual MDS assessment, dated		management for review.		
	12/17/16, indicated Resident 12 required		Date Completed: July 3, 2017		
	extensive assistance of one person		, , ,		
	physical assist for personal hygiene.				
	physical assist for personal hygiene.				
	1				
	A care plan initiated on 9/14/16 and				
	revised on 2/7/17 indicated a an				
	Activities of Daily Living (ADL) self				
	care performance deficit related to				
	diagnosis of mild intellectual disabilities				
	psychosis, and need of assist with				
	dressing and grooming. Interventions				
	included but was not limited to check nail				
	length and trim and clean on bath day as				
	necessary.				
	A review of shower sheets included, but				
	was not limited to, Resident 12 received				
	a shower on 6/1, 6/2, 6/3, 6/5, 6/6, 6/7,				

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

Event ID:

VKEC11 Facility ID: 000446

If continuation sheet Page 43 of 77

PRINTED: 07/26/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155511		î ´	ILDING	nstruction 00	(X3) DATE COMPL 06/13/	ETED	
	PROVIDER OR SUPPLIER	ND REHABILITATION CENTER		830 S 6	NDDRESS, CITY, STATE, ZIP CODE TH ST HAUTE, IN 47807		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	1	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
		No documentation was usal of showers for those					
	Director of Clinia a document titled and indicated the currently being upolicy indicated, care plan shall be resident's daily cavailable to staff responsibility for services to the resulted interpretation and Documentation of the resident's care.  On 6/12/17 at 1:4 Director of Clinia document titled.	d Implementation: 6. must be consistent with e plan"  45 p.m., the Regional cal Operations provided					
	policy was the or by the facility. T "Purpose: The pu are to clean the r trimmed, and to Documentation: information shou resident's medica time that nail car name and title of	he currently being used he policy indicated, urposes of this procedure hail bed, to keep nails prevent infections					

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

Event ID:

VKEC11 Facility ID: 000446

If continuation sheet

Page 44 of 77

PRINTED: 07/26/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	A. BUILDING <u>00</u> COMPLETE			LETED
		155511	B. W	ING		06/13/2017	
				CTDEET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIE	R		830 S 6			
TERRE I	AALITE NI IRSING	AND REHABILITATION CENTER			HAUTE, IN 47807		
	1				11/1012, 114 4/ 00/		•
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	RIATE	COMPLETION
TAG	<b>+</b>	R LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
		the treatment, the					
	1	d the intervention taken.					
	7. The signature	e and title of the person					
	recording the da	ıta."					
	3.1-38(a)(3)						
F 0323	483.25(d)(1)(2)(n	)(1)-(3)					
SS=D	FREE OF ACCID						
Bldg. 00	HAZARDS/SUPE	RVISION/DEVICES					
	(d) Accidents.						
	The facility must	ensure that -					
	(1) The resident of	anvironment remains as					
		environment remains as at hazards as is possible;					
	and	it nazards as is possible,					
	(2) Each resident	receives adequate					
	supervision and a	assistance devices to					
	prevent accidents	5.					
	( ) D   D						
	, , ,	The facility must attempt to					
		alternatives prior to or bed rail. If a bed or side					
		acility must ensure correct					
		and maintenance of bed					
		it not limited to the following					
	elements.	Ç					
	(1) Assess the re						
	entrapment from	bed rails prior to					
	installation.						
	(2) Review the ris	sks and benefits of bed rails					
		or resident representative					
		ned consent prior to					
	installation.	-					
		ne bed's dimensions are					
I	appropriate for th	e resident's size and					

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

Event ID:

VKEC11

Facility ID: 000446

If continuation sheet

Page 45 of 77

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DA			(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	ILDING	00	COMPLI	ETED
		155511	B. WI	NG		06/13/2017	
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	8		830 S 6			
TERRE I	HAUTE NURSING A	AND REHABILITATION CENTER			HAUTE, IN 47807		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES				PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	weight.	11.	F 02	.22	5222		07/12/2017
	Based on record review, and interview,		F 03	523	F323		07/13/2017
	1	d to provide preventative			483.25(d)(1)(2)(n)(1)-(1)-(3) FREE O	)F	
	maintenance for				ACCIDENT		
	(Resident 5), wh	eelchair brakes which			HAZARDS/SUPERVISION/DEVICES		
	resulted in a fall	, and to ensure that					
	resident's side ra	ils were secure while in			The resident environment remains		
	the upright posit	ion for 3 of 3 beds			as free from accident hazards as is		
	observed with ha	alf side rails installed			possible.		
	(Residents 5, 12	, and 24).			4 11	_	
		,			How will the corrective action be accomplished for those residents	e	
	1. On 06/09/17 9:07 a.m., a medical				who are affected by this alleged		
		as completed for			deficient practice?		
	Resident 5.	as completed for					
	Resident 3.				Resident #5 wheelchair brakes wer	·e	
		1 .			repaired to ensure they were		
	The most recent	•			functioning properly.		
	assessment of a						
	`	Set), dated 5/23/17,			Maintenance Director tightened		
		ent 5 had diagnosis			Resident #5, 12, and 24 side rails to		
	including but no	t limited to: muscle			prevent movement while transferring.		
	weakness, depre	ssion, and Psychotic			transferring.		
	Disorder; and a	BIMS (Brief Inventory of			How will the facility identify		
	Mental Status) o	of 4. MDS indicated,			resident having the potential to be		
	"yes the resid	dent had falls since			affected by the same deficient		
	admission/entry	or reentry to the prior			practice?		
	1	ills were coded as 2 or					
		no injuries. MDS			-All residents that use bed rails for		
	indicated that Re	•			mobility and assist with transferring		
		e of transfer between			have the potential to be affected by this alleged deficient practice, as	'	
					well as any resident in a wheelchair	.	
	surfaces including				However, Maintenance Director	-	
		coded as a 3, indicating			completed a facility wide audit of		
	extensive assista	ince.			loose side rails as well as inspecting	.	
					all wheelchairs to ensure brakes		
	A focus care pla	n dated 04/04/17			were functioning properly.		

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

Event ID: VKEC11 Facility ID: 000446

If continuation sheet Page 46 of 77

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPLETED
		155511	B. W	ING		06/13/2017
NAME OF D	ROVIDER OR SUPPLIE	R		STREET A	ADDRESS, CITY, STATE, ZIP CODE	
				830 S 6		
TERRE F	HAUTE NURSING	AND REHABILITATION CENTER		TERRE	HAUTE, IN 47807	
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	-	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	-	sident will attempt at			What measures were put into place	ce
	_	up out of wheel chair by			or systemic changes made to	
	· ·	y of falls" Care plan			ensure that the deficient practice	
		cluded but were not			not recur?	
	· ·	ne resident needs a safe				
	environment"				On 6/26/17Maintenance Director	
					completed facility wide audit of all	
	•	an dated 08/02/16			bed rails including but not limited to tightening of any loose	
	indicated, "Resident has had (perceived/actual) altercation in mood stateexpressions of anxious or				bed rails and measuring bed rails to	
					ensure residents could no	
					become entrapped. Maintenance	
	fidgety/restless	appearance"			Director completed a facility	
					wide inspection to ensure all	
	Nurses notes da	ted 05/03/17 indicated,			wheelchair brakes functioned	
	"Res [resident	] in w/c [wheelchair] in			properly.	
	dining room wa	s attempting to set			All staff were in-serviced on 6/26/1	17
	_	the w/c seat when the w/c			on reporting any loose or poorly	
	rolled backward	ls and resident slid to the			functioning bed rails or	
	floor on his butt	ocksnoted w/c brakes			equipment in the Maintenance	
	were not comple	etely set"			Repair Log book.	
					-Maintenance Director will conduct	t
	A "Nurse Invest	igation of Fall" dated			monthly maintenance audits of all	
	5/3/17 indicated	l, "w/c brakes do not			bed rails.	
	engage- worn- v	v/c rolled backwards"				
					-Maintenance Director will monitor	r
	On 06/09/17, at	10:33 a.m., the			Maintenance Repair Log daily for	,
	-	rector indicated, he had			any items that may need repaired.	,
		looking at wheelchairs,			Tepanea.	
		ance request from 5/3/17			How will the facility monitor its	
	was handled by	-			corrective action?	
		r J				
	06/09/2017 2:40	0:48 p.m., Maintenance			-To ensure compliance, the	
		iployee 24 indicated that			Maintenance Director is responsibl for the completion of monitoring	e
		e been doing maintenance			wheelchair brake function and bed	
1	January Sandarius		1			i i

PRINTED: 07/26/2017 FORM APPROVED OMB NO. 0938-0391

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155511	r í	ILDING	nstruction <u>00</u>	(X3) DATE ( COMPL <b>06/13</b> /	ETED
	ROVIDER OR SUPPLIER	ND REHABILITATION CENTER		830 S 6	DDRESS, CITY, STATE, ZIP CODE TH ST HAUTE, IN 47807		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	]	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	On 06/12/17, at 9. Therapist [PT] 1 Resident 5 was rhis fall on 5/3/17 began working we positioning in his wheelchair seat I bringing the backfront, so that his lower that knee I reports kept indicate.  06/12/17, at 10:0 [Occupational The has worked we including but no strengthening to education with period positioning and we can be seen as the worked we including but no strengthening to education with period positioning and we can be seen as the worked we include the the worked with the worked we worked with the worked worked with the worked we worked we worked we worked with the worked we worked we worked we worked we worked we worked with the worked we worked with the worked we worked with the worked we worked we worked we worked we worked we worked with the worked we worked with the worked we worked with the worked we work	9:59 a.m., Physical 6 indicated that eferred to therapy after 7. PT 16 indicated she with Resident 5 regarding 8 wheelchair and his had been adjusted by 8 down and raising the hips remained a little evel, because his fall cating that he was sliding 13 a.m., OT 25 herapist] indicated that hith the Resident 5 t limited to: core improve trunk control, atient and staff on proper using non-skid socks. 11 1:07 p.m., Resident 5 ting in his wheelchair in history is right 1/2 side rail position and was hose. It wobbled back he mattress, horizontally, h, vertically. Resident 5 did use the bed rails to			rail tightening QAPI audits weekly for four weeks and monthly for six months thereafter until compliance is maintained for two consecutive quarters. The results of the 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 regional operations staff and corporate risk management for review.  Date Completed: July 3, 2017		

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

Event ID:

VKEC11

Facility ID: 000446

If continuation sheet

Page 48 of 77

PRINTED: 07/26/2017 FORM APPROVED OMB NO. 0938-0391

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155511	(X2) MULTIPLE A. BUILDING B. WING	E CONSTRUCTION  O  O	COM	ie survey ipleted 13/2017
	PROVIDER OR SUPPLIER	ND REHABILITATION CENTER	830	ET ADDRESS, CITY, STATE, ZIP S 6TH ST RE HAUTE, IN 47807	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	was observed lay	10:48 a.m., Resident 5 ying in bed with eyes ide rails were observed pright position.				
	indicated that Re	10:15 a.m., LPN 9 esident 5 does use his bed to get himself in and out basis, at least three				
	indicated that Reextensive assists to be lowered in whenever he is it	who needed the side rails to the upright position n bed, and he does use help pull himself upright				
	Resident 5's bed position, and ind between the mat portion of the rai from the mattres while pushed aw	rector measured rail while in the upright icated that the gap tress and the lower most il, measured 4 inches s to the end of the rail ray from the bed. He e bed rail was loose and				
	bed rail for Resid	11:55 a.m., the rector indicated that the dent 5 had been tightened between the mattress and				

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

Event ID:

VKEC11

Facility ID: 000446

If continuation sheet

Page 49 of 77

PRINTED: 07/26/2017 FORM APPROVED OMB NO. 0938-0391

	DF CORRECTION IDENTIFICATION NUMBER:  155511	A. BUILDING  B. WING	00	COMPLETED 06/13/2017
	ROVIDER OR SUPPLIER HAUTE NURSING AND REHABILITATION CENTER	830 S 61	DDRESS, CITY, STATE, ZIP CODE TH ST HAUTE, IN 47807	
(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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	the lower most portion of the rail, measured 2.5 inches from the mattress to the end of the rail while pushed away from the bed.			
	On 06/12/17 at, 1:26 p.m., the Administrator indicated there was no current Policy and Procedure for bed rails and provided a document titled, "Bed Entrapment Assessment." which indicated, "Zone 4: This space is the gap that forms between the mattress compressed by the patient, and the lower most portion of the rail, at the end of the raildimensional limit of less than 60mm (2 3/8 inches) measured between the mattress support platform and the lowest portion of the rail at the rail end to prevent neck entrapment"  Administrator indicated that this assessments what the facility should go by, and that bed rails should never be loose.			
	On 06/12/17, at 1:30 p.m., the Maintenance Director re-measured the tightened bed rail using the guidelines from the provided "Bed Entrapment Assessment" and indicated the gap was measured at 2.5 inches.			
	On 06/09/17 9:07 a.m., a medical record review was completed for Resident 5.			

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

Event ID:

VKEC11

Facility ID: 000446

If continuation sheet

Page 50 of 77

PRINTED: 07/26/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		î /		NSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		JILDING	00	COMPL	
		155511	B. W	ING		06/13/	2017
NAME OF F	PROVIDER OR SUPPLIEF	3		STREET A	DDRESS, CITY, STATE, ZIP CODE		
				830 S 6			
TERRE H	HAUTE NURSING A	AND REHABILITATION CENTER		TERRE	HAUTE, IN 47807		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	The most recent	•					
	assessment of a						
	`	Set), dated 5/23/17,					
	indicated Reside	ent 5 had diagnosis					
	including but no	t limited to: muscle					
	weakness, depre	ssion, and Psychotic					
	Disorder, and a	BIMS (Brief Inventory of					
	Mental Status) o	of 4. MDS indicated,					
	"yes the resid	dent has had falls since					
	admission/entry	or reentry of the prior					
	assessment" fa	alls were coded as "2 or					
	more falls with 1	no injuries." MDS					
	indicated that Re	esident 5's					
	self-performance	e of transfer between					
	_	ng to or from the bed,					
		B, meaning extensive					
	assistance.	,,,					
	A focus care pla	n dated 04/04/17					
		sident displays moderate					
		decision makingBIMS					
	score is between	_					
		. •					
	A focus care pla	n dated 04/04/17					
		sident will attempt at					
	-	ip out of wheel chair by					
	_	y of falls" Care plan					
		cluded but were not					
	environment"	ne resident needs a safe					
	environment"						
	A focus core pla	n dated 08/02/16					
	indicated, "Re						
	(perceived/actua	al) altercation in mood	1				

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

Event ID:

VKEC11 Facility ID: 000446

If continuation sheet

Page 51 of 77

PRINTED: 07/26/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155511		(X2) MULTIF A. BUILDII B. WING		nstruction <u>00</u>	(X3) DATE COMPL <b>06/13</b> /	ETED	
	PROVIDER OR SUPPLIEF	AND REHABILITATION CENTER	83	0 S 6	DDRESS, CITY, STATE, ZIP CODE TH ST HAUTE, IN 47807		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TA		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	stateexpression fidgety/restless a						
	5/26/17, that ind more would be o	sessment" completed icated a score of 10 or considered a "high fall was scored at a 13.					
	A "Quarterly Nursing Assessment" for March of 2017 indicated that Resident 5's bed rails were properly installed and that the gap between the rails/bed frame and mattress edges was not greater than 2.5 inches.						
	was observed to to the outer side	2:08 p.m., Resident 12 have a quarter side rail of the bed. The rail was bose, moved back and ed on.					
	rail to the bed w	33 a.m., the quarter side as observed to be loose, forth when pulled on.					
	p.m., Resident 1	niew on 6/9/17 at 3:07 2 indicated he used the sed to position himself.					
	a.m., the restorat	riew on 6/12/17 at 9:33 tive CNA 12 indicated If the quarter side rail to Fibed.					
	During an interv	riew on 6/12/17 at 10:37					

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

Event ID:

VKEC11 Facility ID: 000446

If continuation sheet

Page 52 of 77

PRINTED: 07/26/2017 FORM APPROVED OMB NO. 0938-0391

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155511			(X2) MULTIPLE CONSTRUCTION       (X3) DATE SURVEY         A. BUILDING       00       COMPLETED         B. WING       06/13/2017				
	PROVIDER OR SUPPLIEI	AND REHABILITATION CENTER		830 S 6	DDRESS, CITY, STATE, ZIP CODE TH ST HAUTE, IN 47807			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE	
	·	or of Nursing (DON) sident used the side rail if						
	a.m., the Mainte that Resident 12	riew on 6/12/17 at 11:22 enance Director indicated 's side rail was not in condition and needed to be						
	6/9/17 at 9:02 a. care plan include	cord was reviewed on m. Diagnosis from the ed, but were not limited walking, low back pain ed mobility.						
	12/17/16, indical independent for required no physindependent for surfaces including	assessment, dated ted Resident 12 was bed mobility and sical help from staff and transfers (moves between ng to or from bed) and sical help from staff.						
	revised on 4/5/1 had potential for psychotropic metransfers self, in mobility and had 4. On 6/12/17 at random observa	edication use, resident dependent for bed d poor safety awareness. 8:50 a.m., during a tion of Resident 24's ail (left facing head of						

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

Event ID:

VKEC11

Facility ID: 000446

If continuation sheet

Page 53 of 77

PRINTED: 07/26/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155511		(X2) MULTIPL A. BUILDING B. WING		TION	(X3) DATE COMPL <b>06/13</b> /	ETED	
		ND REHABILITATION CENTER	830	S 6TH ST	S, CITY, STATE, ZIP CODE E, IN 47807		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EAC CROSS	PROVIDER'S PLAN OF CORRECTION CH CORRECTIVE ACTION SHOULD I S-REFERENCED TO THE APPROP DEFICIENCY)	E	(X5) COMPLETION DATE
	random environr Maintenance Din rail was observed During an interv a.m., the DON (	iew, on 6/12/17 at 10:23 director of nursing)					
	for bed mobility						
	a.m., Physical Tl indicated the res pull himself up t	iew, on 6/12/17 at 11:02 herapist (PT) 16 ident used his side rail to o a sitting position at getting out of bed.					
	a.m., Restorative resident used his himself both to a bed and to assist several times a d not be loose fitte	iew, on 6/12/17 at 11:09 e CNA 12 indicated the side rail to assist a sitting position in his himself to stand up ay. The bedrails should d to a bed. A loose rail em if a resident used it to es.					
	a.m., the Mainter the resident's rail						

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

Event ID:

VKEC11 Facility ID: 000446

If continuation sheet

Page 54 of 77

PRINTED: 07/26/2017 FORM APPROVED OMB NO. 0938-0391

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155511	(X2) MUI A. BUI B. WIN	LDING	NSTRUCTION  00	(X3) DATE ( COMPL 06/13/	ETED	
	ROVIDER OR SUPPLIER	ND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE  830 S 6TH ST  TERRE HAUTE, IN 47807					
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	Р	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE	
	p.m., the Region Operations indic policy for side ra	iew, on 6/12/17 at 1:28 al Director of Clinical ated they did not have a alils, but rails should not all fit securely to the						
	a.m., the Admini "Preventative Ma Inspection Requi	strator indicated the aintenance Testing & irements," was the sing used by the facility.						
	Inspection Requite policy was the used by the facile "NFPA Life Safe Edition) & GHC Inspections23.	rector provided a 7/20/08, titled, aintenance Testing & irements," and indicated he one currently being hety. The policy indicated, hety Code-101 (2000 C Required Tests & Resident Items: A. hedbolt tightnessB. horoper operation of						
F 0327 SS=D Bldg. 00	3.1-45(a)(1) 3.1-45(a)(2) 483.25(g)(2) SUFFICIENT FLU HYDRATION (g) Assisted nutriti							
		stric and gastrostomy						

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

Event ID:

VKEC11

Facility ID: 000446

If continuation sheet

Page 55 of 77

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			r í		ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLET  B. WING 06/13/20				
		155511	B. WI	NG		06/13/	2017
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
				830 S 6			
TERRE F	HAUTE NURSING A	AND REHABILITATION CENTER		TERRE	HAUTE, IN 47807		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a						
		hensive assessment, the					
	facility must ensur						
	(0)  # #:	ain and Albaird installand to					
	· '	cient fluid intake to ydration and health.					
		ation, interview, and	F 03	327	F327		07/13/2017
		e facility failed to	1 0.	, = 1			07/13/2017
		e fluids for 1 of 1			483.25(g)(2)		
	residents review						
		ed for hydration			SUFFICIENT FULUID TO MAINTAIN		
	(Resident 4).				HYDRATION		
	Findings in deal				Based on a resident's		
	Findings include	).			comprehensive assessment, the		
	0 (517	0			facility must ensure that a		
		0 p.m., Resident 4's lips			resident-is offered sufficient fluid		
	were noted to be	dry.			intake to maintain proper		
					hydration and health.		
		8 p.m., Resident 4 was			1. How will the corrective		
		ating lunch in her room,			action be accomplished for those		
	no drinks were p	provided for lunch.			residents who are affected by this		
					alleged deficient practice?		
		6 p.m., Resident 4's					
		room was observed to be			-Resident #4 hydration needs were		
		l with no ice. No straw			assessed to ensure adequate fluids		
	or cup were obse	erved in Resident 4's			are provided. Care plans were updated to reflect to the necessary		
	room. Lips were	e dry.			changes.		
	On 6/9/17 at 10:	31 a.m., Resident 4 was					
	observed to be si	itting up in the					
	wheelchair in he	r room, lips were dry.			2. How will the facility identify		
					resident having the potential to be affected by the same deficient		
	During a second	lunch observation on			practice?		
	_	o.m., Resident 4 was			F. 22		
	1	•			-All residents in the facility could		

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

Event ID:

Facility ID: 000446

VKEC11

If continuation sheet

Page 56 of 77

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPLETED
		155511	B. WI	NG		06/13/2017
				CEDEET	ADDRESS OFTWO STATE ZID CODE	
NAME OF P	ROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP CODE	
		AND DELIABILITATION CENTED		830 S 6		
I ERRE F	HAUTE NURSING A	AND REHABILITATION CENTER		IERRE	HAUTE, IN 47807	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	served lunch wit	th 8 ounces of coffee. No			potentially be affected by this	
	fluid choices were offered. Staff was not				practice. The hydration needs of all	
					residents were reviewed by MDS fo	r
	observed to encourage Resident 4 to drink her fluids.				accuracy. Any discrepancies were	
	drink her muids.				corrected.	
	On 6/9/17 at 12:	31 p.m., Resident 4			3. What measures were put	
	asked for lemona	ade to go with lunch.			into place or systemic changes	
	Lemonade was s	served as requested.			made to ensure that the deficient	
		4			practice not recur?	
	During on interv	riew on 6/9/17 at 10:12				
	_				-On 6/26/17 all staff were	
	· ·	or of Nursing (DON)			in-serviced on offering residents 2-3	
		were documented in the			drink options per meals.	
	Certified Nursin	g Assistant's (CNA)				
	computer chartir	ng only. Fluids were not			-On 6/26/17 Nursing Staff were	
	•	where else in the record.			in-serviced on encouraging fluids to	
	1	ydration concerns that			resident to ensure adequate	
		unicated to the DON.			hydration and passing fresh ice	
	nad been commi	inicated to the DON.			water every shift.	
					On 6/26/17 Dietary Staff were	
	Resident 4's reco	ord was reviewed on			in-serviced on stocking the	
	6/8/17 at 1:24 p.:	<ul> <li>m. A admission record,</li> </ul>			hydration cart for use after hours	
	dated 4/19/17, in	ncluded, but was not			and having hydration cart be	
	· · · · · · · · · · · · · · · · · · ·	oid schizophrenia, major			accessible for use	
	_	der, type II diabetes			decession for use	
	*					
		complications, edema,				
	-	nageal reflux disease			4. How will the facility monitor	
	without esophag	itis.			its corrective action?	
	A nutrition asses	ssment, dated 2/4/17,			To ensure compliance, the DON is	
		s not limited to, a fluid			responsible for the completion of	
	•	lliliters (ml) daily.			fluid intake monitoring QAPI audits	
					weekly for four weeks and monthly	
	_	onsumption with meals			for six months thereafter until	
	was 480-600 ml.	•			compliance is maintained for two	
					consecutive quarters. It is the	
	A review of Res	ident 4's daily fluid			Dietary Manager responsibility to	

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

Event ID:

VKEC11 Facility ID: 000446

If continuation sheet Page 57 of 77

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION (X3) DATE SUI			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPLETED
		155511	B. WI	ING		06/13/2017
				CTDEET A	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIEF	₹				
TEDDE	LALITE NUIDOINO /	AND DELIABILITATION CENTED		830 S 6		
I EKKE F	HAUTE NURSING A	AND REHABILITATION CENTER		TERRE	HAUTE, IN 47807	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	consumption inc	licated the following:			stock the hydration cart for use after	er
	1	S			hours QAPI audits weekly for four	
	a 5/28/17: No fl	luid consumption or			weeks and monthly for six months	
		_			thereafter until compliance is	
	refusal was docu	imented.			maintain for two consecutive	
					quarters. The results of the audits	
	b. 5/29/17-6/2/1	7: Resident 4 was out of			will be reviewed by the QAPI	
	the facility to the	e hospital.			committee monthly. If 95%	
		•			compliance is not achieved, an	
	c 6/3/17 Reside	ent 4 returned from the			action plan will be developed and	
		sumed 480 ml of fluids			implemented. Monthly QAPI	
	*				minutes and action plans are	
	the remainder of	the day.			submitted to regional operations	
					staff and corporate risk	
	d. 6/4/17: 960 m	1.			management for review.	
	e. 6/5/17: 1200 r	nl			Date Completed: July 3, 2017	
	C. 0/3/17. 1200 1	111.				
	0.61611.7.060					
	f. 6/6/17: 960 m	1.				
	g. 6/7/17: 480 m	1.				
	h. 6/8/17: 1180 1	ml				
	11. 0/0/17. 1100 1					
		1 1 1 1 1 1 1 1 1 1 1 1 1				
		der, dated 8/8/16,				
	included, but wa	-				
	furosemide (a di	uretic) 40 milligram				
	(mg) tablet, give	e 1 tablet by mouth daily				
	for edema.					
	Tor Cucina.					
	A mhyraigianta andan deted (12/17					
	A physician's order, dated 6/3/17,					
	included, but was not limited to, Bactrim					
	double strength (an antibiotic), 1 tablet by					
	mouth twice dai	ly for 7 days for urinary				
	tract infection (U					
	(	/-				

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

Event ID:

VKEC11 Facility ID: 000446

If continuation sheet Page 58 of 77

PRINTED: 07/26/2017 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER TERRE HAUTE NURSING AND REHABILITATION CENTER  (XX) ID SUMMARY STATEMENT OF DEFICIENCES (FACH DEFICIENCY MUST BE PRECEDED BY PULL TAG  A dehydration risk assessment, dated 6/3/17, included, but was not limited to, risk factors for dehydration of urinary tract infection, diabetes, and routine diurctics.  A care plan, initiated on 9/23/15, and last revised on 5/15/17, included, but was not limited to, a focus of resident had the potential for fluid deficit and dehydration. A goal, included, but was not limited to, resident will be free from symptoms of dehydration and will maintain moist mucous membranes. Interventions included, but were not limited to, administer medications as ordered and monitor/document/report to physician any signs or symptoms of dehydration, and obtain and monitor lab/diagnostic work as ordered and report results to physician and follow up as indicated.  On 6/12/17 at 12:54 p.m., the Regional Director of Clinical Operations provided a document, dated November 2014, titled, "Weight/Hydration Management," and indicated the policy was the one currently being used by the facility. The		IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155511	· /	JILDING	nstruction <u>00</u>	(X3) DATE COMPL <b>06/13</b> /	ETED
PRETIX TAG  REGULATORY OR LSC IDENTIFYING INFORMATION, A dehydration risk assessment, dated 6/3/17, included, but was not limited to, risk factors for dehydration of urinary tract infection, diabetes, and routine diuretics.  A care plan, initiated on 9/23/15, and last revised on 5/15/17, included, but was not limited to, a focus of resident had the potential for fluid deficit and dehydration. A goal, included, but was not limited to, resident will be free from symptoms of dehydration and will maintain moist nucous membranes. Interventions included, but were not limited to, administer medications as ordered and monitor/document side effects, encourage the resident to drink fluids of choice, invite resident to activities that promote additional fluid intake, offer drinks during one on one visits, monitor/document/report to physician any signs or symptoms of dehydration, and obtain and monitor lab/diagnostic work as ordered and report results to physician and follow up as indicated.  On 6/12/17 at 12:54 p.m., the Regional Director of Clinical Operations provided a document, dated November 2014, titled, "Weight/Hydration Management," and indicated the policy was the one					830 S 6	TH ST		
6/3/17, included, but was not limited to, risk factors for dehydration of urinary tract infection, diabetes, and routine diurcties.  A care plan, initiated on 9/23/15, and last revised on 5/15/17, included, but was not limited to, a focus of resident had the potential for fluid deficit and dehydration. A goal, included, but was not limited to, resident will be free from symptoms of dehydration and will maintain moist mucous membranes. Interventions included, but were not limited to, administer medications as ordered and monitor/document side effects, encourage the resident to activities that promote additional fluid intake, offer drinks during one on one visits, monitor/document/report to physician any signs or symptoms of dehydration, and obtain and monitor lab/diagnostic work as ordered and report results to physician and follow up as indicated.  On 6/12/17 at 12:54 p.m., the Regional Director of Clinical Operations provided a document, dated November 2014, titled, "Weigh/Hydration Management," and indicated the policy was the one	PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	λΤΕ	COMPLETION
i currently being used by the racinity. The		A dehydration ri 6/3/17, included risk factors for d tract infection, d diuretics.  A care plan, initiate revised on 5/15/limited to, a focupotential for fluidehydration. A substitution of the potential for fluidehydration of delimited to, resymptoms of delimited to, adminordered and more effects, encourage fluids of choice, activities that provintake, offer drin visits, monitor/d physician any significant of the physician and lab/diagnostic wresults to physician and lab/diagnostic w	sk assessment, dated but was not limited to, ehydration of urinary liabetes, and routine ated on 9/23/15, and last 17, included, but was not as of resident had the deficit and goal, included, but was sident will be free from hydration and will nucous membranes. Eluded, but were not hister medications as hitor/document side ge the resident to drink invite resident to bomote additional fluid liks during one on one occument/report to gas or symptoms of a obtain and monitor ork as ordered and report ian and follow up as as 12:54 p.m., the Regional cal Operations provided and November 2014, Hydration Management," the policy was the one					

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

Event ID:

VKEC11 Facility ID: 000446

If continuation sheet

Page 59 of 77

PRINTED: 07/26/2017 FORM APPROVED OMB NO. 0938-0391

		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BU	ILDING	NSTRUCTION  00	(X3) DATE : COMPL	ETED
		155511	B. WI	NG		06/13/	2017
	ROVIDER OR SUPPLIER			830 S 6			
		AND REHABILITATION CENTER		TERRE	HAUTE, IN 47807		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	]	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
		"Overviewresidents h sufficient fluid intake er hydration and					
F 0329 SS=D Bldg. 00	resident's drug reg unnecessary drug any drug when use	DRUGS Drugs-General. Each gimen must be free from s. An unnecessary drug is					
	drug therapy); or (2) For excessive (	duration; or					
	(3) Without adequa	ate monitoring; or					
	(4) Without adequa	ate indications for its use;					
		e of adverse ich indicate the dose d or discontinued; or					
		ons of the reasons stated 1) through (5) of this					
	the facility failed (gradual dose rec antipsychotic me when recommend	edication was attempted ded for 1 of 5 residents	F 03	29	F329  483.45(d)€(1)-(2)DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS  Unnecessary Drugs-General. Each		07/13/2017
	reviewed for unn	necessary medications			resident's drug regimen must be		

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

Event ID:

VKEC11 Facility ID: 000446

If continuation sheet

Page 60 of 77

STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	JLTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	ILDING	00	COMPLI	ETED
		155511	B. WI	NG		06/13/	2017
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEF	₹		830 S 6			
TERRE H	HAUTE NURSING A	AND REHABILITATION CENTER			HAUTE, IN 47807		
			1	l		Г	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL  LISC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION DATE
IAU		LESC IDENTIFTING INFORMATION)		TAG			DATE
	(Resident 7).				free from unnecessary drugs.		
					How will the corrective		
	Findings includ	e:			action be accomplished for those		
	The record for Resident 7 was reviewed				residents who are affected by this		
					alleged deficient practice?		
	on 6/8/17 at 1:24	4 p.m. Diagnosis from the					
	care plan include	ed, but were not limited			-Resident #7medication regimen to		
	to paranoid pers				be evaluated by psychologist and		
		ehaviors, psychosis,			attending physician, changes will be		
	agitation, and pa				made if deemed as appropriate.		
	agnation, and pa	iranoia.			2		
	A	down!! in alredod book			2. How will the facility identify		
		ders" included, but was			resident having the potential to be affected by the same deficient		
		lloperidol (antipsychotic)			practice?		
		s) tablet give 1 tablet by			<b>P</b>		
		e for paranoia start date			-All residents on psychotropic		
	10/2/15.				medication have the potential to be		
					affected by this alleged deficient		
	A pharmacy rep	ort titled, "Consultation			practice. A review was made of the		
	Report" and, dat	ted 10/21/16, indicated,			last 30 days' worth of pharmacy		
	"Comment: Re	esident 7 has received			recommendations to ensure no		
	haloperidol 1 mg	g since 10/15.			other recommendations were missed.		
	-	n: please consider a					
		luction (GDR) to			3. What measures were put		
	_	ng HS (at bedtime)			into place or systemic changes		
	*	mmendation: federal			made to ensure that the deficient		
		ire that antipsychotics			practice not recur?		
		eat a psychiatric disorder					
	_	east quarterly with					
					-On 6/26/17 all nursing staff were		
		egarding continue			in-serviced on new procedures for		
		ateness and undergo gdr			evaluation, monitoring		
		parate quarters within the			signs/symptoms and behaviors with		
		ch a resident is admitted			medications of psychotropic nature,		
		ity has initiated the			notifying the physician of changes in	n	
	medication, then	annually Physicians			patient conditions, as well as		

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

Event ID:

VKEC11 Facility ID: 000446

If continuation sheet

Page 61 of 77

PRINTED: 07/26/2017 FORM APPROVED OMB NO. 0938-0391

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155511		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 06/13/2017
	PROVIDER OR SUPPLIEF	AND REHABILITATION CENTER	830 S 6	ADDRESS, CITY, STATE, ZIP CODE 3TH ST E HAUTE, IN 47807	•
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	above because C	. signed by physician		resident family members.  -DON will be monitoring GDR with IDT and physicians monthly	
	indicated, conting QHS (every bedifailed dose reduction failed attempted for haoperidol fr 10/21/16 (the reduction the annual gdr).  A review of Carnot limited to, "I for drug related of psychotropic Interventions with included, but we administer mediagradual dose reduction state guidelines."  A review of MD quarterly assessing included, but was indicators of psychotropic state guidelines. A review of MD quarterly assessing included, but was indicators of psychotropic state guidelines. A review of MD quarterly assessing included, but was indicators of psychotropic state guidelines. A review of MD quarterly assessing included, but was indicators of psychotropic state guidelines. A review of MD quarterly assessing included, but was indicators of psychotropic state guidelines. A review of MD	th a revised ate of 2/7/17 re not limited to cation as ordered, uction (GDR) per federal ' S (minimum data set) ment, dated 5/10/16, s not limited to potential chosis: none and tom presence and vior not exhibited. S quarterly assessment,		4. How will the facility monitor its corrective action?  -To ensure compliance, the DON is responsible for monitor and following pharmacy recommendations for GDR, conduction chart audits and physician progress notes verifying GDRs are being achieved QAPI audits weekly for foweeks and monthly for six months thereafter until compliance is maintained for two consecutive quarters. The results of the 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 regional operations staff and corporate risk management for review.  Date Completed: July 3, 2017	ct s our
		cluded, but was not			

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

Event ID:

VKEC11 Facility ID: 000446

If continuation sheet

Page 62 of 77

PRINTED: 07/26/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155511		(X2) MULTIPI A. BUILDIN B. WING			(X3) DATE COMPL 06/13	ETED		
	PROVIDER OR SUPPLIEF	AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE  830 S 6TH ST  TERRE HAUTE, IN 47807					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAC	CR	PROVIDER'S PLAN OF CORRECTION EACH CORRECTIVE ACTION SHOULD BE OSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE	
		tial indicators of and behavioral symptom quency: behavior not						
	assessment, date was not limited to psychosis: none, presence and fre	est comprehensive and 9/9/16, included, but to potential indicators of the behavioral symptom and equency: behavior not the verall presence of the bottoms: no.						
	p.m., the MDS c could not find a reduction of halo	riew on 6/9/17 at 1:54 coordinator indicated she failed attempted drug operidol between the 2015 through October						
	p.m., CNA 13 in exhibited behavi	riew on 6/9/17 at 2:29 adicated if a resident has iors she would report it to art the behavior in the						
	a.m., [physican i	riew on 6/12/17 at 11:51 name] indicated the last for haloperidol he found s on 10/2/15.						
		46 p.m., the Regional ical Operations provided Psychotropic						

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

Event ID:

VKEC11 Facility ID: 000446

If continuation sheet

Page 63 of 77

PRINTED: 07/26/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155511		Ì	ILDING	NSTRUCTION  00	(X3) DATE COMPL <b>06/13</b> /	ETED	
	ROVIDER OR SUPPLIER	ND REHABILITATION CENTER		830 S 6	DDRESS, CITY, STATE, ZIP CODE TH ST HAUTE, IN 47807		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
F 0371 SS=D Bldg. 00	currently being to policy included, " 13. the physic pharmacist will in the resident and in the developmed maintain the resident for the potential psychoactive mereviewed at the replan meeting"  3.1-48(b)(2)  483.60(i)(1)-(3) FOOD PROCURE STORE/PREPARI (i)(1) - Procure for considered satisfor local authorities (i) This may included in the provision of the potential psychoactive mereviewed at the replan meeting"	esident's quarterly care  E/SERVE - SANITARY of from sources approved sfactory by federal, state is le food items obtained producers, subject to nd local laws or  does not prohibit or om using produce grown subject to compliance fe growing and ctices.  does not preclude					

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

Event ID:

VKEC11 Facility ID: 000446

If continuation sheet

Page 64 of 77

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE S			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	ILDING	00	COMPL	ETED
		155511	B. WI	NG		06/13/	2017
NAME OF D	PROVIDER OR SUPPLIER		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	KOVIDEK OK SOLI EIEN			830 S 6			
TERRE H	HAUTE NURSING A	AND REHABILITATION CENTER		TERRE	HAUTE, IN 47807		
(X4) ID		TATEMENT OF DEFICIENCIES			PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE OF THE APPROPRIATE	ГЕ	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	procured by the fa	icility.					
	(i)(2) - Store, prep	are, distribute and serve					
		e with professional					
	standards for food	l service safety.					
	(1) (2) 11						
		y regarding use and rought to residents by					
		isitors to ensure safe and					
	sanitary storage, h						
	consumption.						
	Based on observ	ation, interview, and	F 03	371	F371		07/13/2017
	record review, th	ne facility failed to ensure					
	food and drinks	were served under			483.60(i)(1)-(3) FOOD PROCURE,		
	sanitary conditio	ons, during 2 of 2 dining			STORE/PREPARE/SERVE-SANITARY		
	observations.				Have a policy regarding use and		
					storage of foods brought to		
	Findings include	»:			residents by family and other by		
	_				visitors to ensure safe and sanitary		
	On 6/07/17 at 11	:59 a.m., during initial			storage, handling, and		
		on, CNA (Certified			consumption.		
	_	was observed holding			1. How will the corrective action be	2	
		inking glass around the			accomplished for those residents		
	rim with her bard	e hands.			who are affected by this alleged		
					deficient practice?		
	On 6/13/17 at 12	2:07 p.m., during a			When brought to facility to attend to		
	random meal obs				-When brought to facility's attention on 6/13/17, after meal service had	ı	
		se) 26 was observed			been completed that staff members		
	, ·	nt 14's bread with her			improperly handled food items and		
	bare hands when				drinking glasses. All staff members		
	Date Hallus Wileli	outtering it.			were immediately in-serviced on		
	During an interv	iew, on 6/13/17 at 12:28			Food Service.		
					2 11-11-11-11-1		
	_	licated it was never okay			2. How will the facility identify resident having the potential to be		
	1 -	ach the rims of drinking			affected by the same deficient		
	-	with their bare hands,			practice?		
	when serving the	e resident meals.			p. actice.		

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

Event ID:

VKEC11 Facility ID: 000446

If continuation sheet Page 65 of 77

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SUF	RVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		JILDING	00	COMPLETI	
		155511	B. W	ING		06/13/20	17
NAME OF D	PROVIDER OR SUPPLIER	,		STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER			830 S 6	TH ST		
TERRE H	HAUTE NURSING A	AND REHABILITATION CENTER		TERRE	HAUTE, IN 47807		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE C	OMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
					-All residents in the facility could		
	During an interv	iew, on 6/13/17 at 12:32			potentially be affected by this		
	p.m., RN 26 ind	icated staff should not			practice. Education given to all staff		
	touch food with	their bare hands when			with particular emphasis on safe		
	serving or assist	ing with resident meals.			food handling while assisting a		
		<u> </u>			resident to eat.		
	On 6/13/17 at 1:	09 p.m., the Regional			3. What measures were put into		
		ical Operations provided			place or systemic changes made to		
					ensure that the deficient practice		
	•	ed 2009, titled, "Dietary			not recur?		
	•	ndicated the policy was					
	the one currently	being used by the			-All staff were in-serviced on		
	facility. The poli	icy indicated, "Purpose:			6/13/17 on safe food handling and		
	To prevent conta	amination of food			meal service.		
	productsVI. Pr	oper Food Handling:					
	•	servedso as to avoid			-Residents also educated during a		
		of prepared foodsG.			Resident Council meeting that they		
					have the right to request new meal		
	Fingers are to be	e kept out of food"			items if they feel they were		
	0.1.01(*)(0)				improperly handled.		
	3.1-21(i)(3)				4. How will the facility monitor its		
					corrective action?		
					-To ensure compliance, the		
					Department Heads are responsible		
					for monitoring adequate food/drink		
					handling QAPI audits weekly for fou	r	
					weeks and monthly for six months		
					thereafter until compliance is		
					maintained for two consecutive		
					quarters. Activity Director is		
					responsible for asking residents if		
					they have any complaints/concerns		
					related to handling of food during	,	
					Resident Council QAPI audits weekly	<i>'</i>	
					for four weeks and monthly for six	,	
					months until compliance is achieved	,	
			1		for two consecutive quarters. The		

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

Event ID:

VKEC11 Facility ID: 000446

If continuation sheet

Page 66 of 77

PRINTED: 07/26/2017 FORM APPROVED OMB NO. 0938-0391

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155511	(X2) MUI A. BUII B. WIN	LDING	nstruction <u>00</u>	(X3) DATE : COMPL 06/13/	ETED
	PROVIDER OR SUPPLIER	ND REHABILITATION CENTER		830 S 6	NDDRESS, CITY, STATE, ZIP CODE TH ST HAUTE, IN 47807		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	P	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
F 0441 SS=D Bldg. 00	The facility must e prevention and co must include, at a elements:  (1) A system for preporting, investiginfections and con all residents, staff, other individuals prontractual arrang facility assessment §483.70(e) and for standards (facility implementation is  (2) Written standar procedures for the include, but are not identify possible contraction.	ntion and control program.  stablish an infection ntrol program (IPCP) that minimum, the following reventing, identifying, ating, and controlling nmunicable diseases for volunteers, visitors, and roviding services under a ement based upon the at conducted according to llowing accepted national assessment Phase 2);  rds, policies, and a program, which must on limited to:  veillance designed to communicable diseases or they can spread to other			results of the 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 regional operations staff and corporate risk management for review.  Date Completed: July 3,2017		

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

Event ID:

VKEC11

Facility ID: 000446

If continuation sheet

Page 67 of 77

PRINTED: 07/26/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE	LETED	
AND PLAN	OF CORRECTION	155511	B. WING	G <u>00</u>	<del>_</del>	3/2017
		155511			_	0/2017
NAME OF F	PROVIDER OR SUPPLIER	t		EET ADDRESS, CITY, STATE, ZIP (	CODE	
TEDDE	LALITE NUIDOINO A	AND DELIABILITATION CENTED		S 6TH ST		
TERRE	TAUTE NURSING F	AND REHABILITATION CENTER	IER	RRE HAUTE, IN 47807		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO		(X5)
PREFIX	•	CY MUST BE PRECEDED BY FULL	PREFIX	CROSS-REFERENCED TO THE	SHOULD BE APPROPRIATE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)		DATE
		whom possible incidents of sease or infections should				
		transmission-based followed to prevent spread				
		v isolation should be used uding but not limited to:				
	depending upon the organism involved (B) A requirement	that the isolation should ctive possible for the				
	facility must prohil communicable dis lesions from direct	nces under which the bit employees with a sease or infected skin t contact with residents or contact will transmit the				
		iene procedures to be nvolved in direct resident				
		ecording incidents e facility's IPCP and the taken by the facility.				
		nnel must handle, store, sport linens so as to d of infection.				
	an annual review their program, as	The facility will conduct of its IPCP and update necessary. ation, interview, and	F 0441	F441		07/13/2017
		,				1

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

Event ID:

VKEC11

Facility ID: 000446

If continuation sheet

Page 68 of 77

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DA		(X3) DATE S	3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPLI	ETED
		155511	B. WI	ING		06/13/2	2017
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER	t .		830 S 6			
TEDDE I	ANTITE NITIDSING /	AND REHABILITATION CENTER			HAUTE, IN 47807		
					117012, 111 47007		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	record review, the facility failed to ensure proper cleaning, storage and weekly			483.80(a)(a)(2)(4)(e)(f) INFECTION			
	changing of neb	ulizer equipment for 1 of			CONTROL, PREVENT SPREAD, LINENS		
	5 resident's revie	ewed for unnecessary			LINENS		
	medications (Re	sident 7).			The facility must establish an		
	,	,			infection prevention and control		
	Findings include	••			program that must include at a		
	1 manigs merade	··			minimum a system for preventing,		
	On 6/7/17 of 11.	26 a.m., Resident 7 was			identifying, reporting, investigation	١,	
		<i>'</i>			and controlling infections and		
		ng self a breathing			communicable diseases for all		
		completed the resident			residents, staff, volunteers, visitors	,	
		ine off and placed tubing			and other individuals providing		
	and mouthpiece	onto bedside table, and			services under a contractual		
	did not place in	bag.			arrangement.		
					How will the corrective action be	<u> </u>	
	On 6/9/17 at 8:5	7 a.m., Resident 7's			accomplished for those residents	·	
	nebulizer tubing	and mouth piece were			who are affected by this alleged		
	observed on bed	side table, not placed			deficient practice?		
	inside of bag.	•					
					-Resident #7 re-educated on placing	;	
	On 6/9/17 at 2:0	8 p.m., Resident 7's			nebulizer tubing and mouth piece		
		and mouth piece were			into a plastic bag; resident refuses to place items in bag. After		
	_	side table, not placed			resident does breathing treatment,		
	inside of bag.	side table, not placed			nursing will clean /dry out		
	iliside of bag.				medication cup of the mouth piece,		
	0(10/17 : 11	.02 P 1 7'			place the tubing, mouth piece		
		:02 a.m., Resident 7's			into a bag labeled with		
	_	and mouth piece were			resident's name and place in med		
		side table, not placed			cart.		
		ne bag used for storage of					
	nebulizer equipment was observed laying				2. How will the facility identify		
	on resident's night stand and was dated				resident having the potential to be		
	6/5/17, the nebu	lizer tubing was also			affected by the same deficient		
	dated 6/5/17.	-			practice?		
					-All resident that self-administration	)	

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

Event ID:

VKEC11 Facility ID: 000446

If continuation sheet Page 69 of 77

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	ILDING	00	COMPL	ETED
		155511	B. WI	NG		06/13/	/2017
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEF	₹		830 S 6			
TERRE H	HAUTE NURSING A	AND REHABILITATION CENTER			HAUTE, IN 47807		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE.	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		21 a.m., Resident 7's			could potentially be affected.		
	nebulizer tubing	and mouth piece were			However, those resident that		
	observed on bed	side table, not placed			perform self-administration of nebulizer treatment were assessed		
	inside of bag. The bag used for storage of				immediately and will continue to be		
	nebulizer equipn	ment was observed laying			monitored quarterly for their ability		
		ht stand and was dated			to self-administer medications.	•	
	_	lizer tubing was also					
	dated 6/5/17.	nzer taemig was also			3. What measures were put into		
	dated 0/3/17.				place or systemic changes made to		
	Dagidant 71g mags	ord was reviewed on			ensure that the deficient practice		
					not recur?		
	_	m. The diagnosis on the					
		ed, but was not limited to			-All nursing staff were in-serviced o	n	
	COPD (Chronic	Obstructive Pulmonary			the proper cleaning/drying, and		
	Disease) and alle	ergies.			storage of nebulizer tubing and		
					medication cup.		
	A review of phy	sicians orders included,			-Handling of nebulizer equipment		
	but was not limit	ted to, start date 9/29/16			was added to the MAR for		
	budesonide (ster	oid and decongestant)			documentation and accountability		
		rams)/ 2 ml (milliliters)					
		le 2 ml via nebulizer			4. How will the facility monitor its		
	_	deliver medication in the			corrective action?		
	`						
	· ·	2 times a day, after use:			-To ensure compliance, the DON is		
	rinse mouth and	spit.			responsible monitoring resident  MARs for documentation and the		
					storage of nebulizer equipment		
		original comprehensive			QAPI audits weekly for four weeks		
	physician's order	r sheet dated 3/19/17			and monthly for six months		
	included, but wa	is not limited to, resident			thereafter until compliance is		
	may administer	nebulizer treatments to			maintained for two consecutive		
	self.				quarters. The results of the audits		
					will be reviewed by the QAPI		
	During an interv	riew on 6/9/17 at 2:04			committee monthly. If 95%		
	p.m., Resident 7				compliance is not achieved, an		
	_				action plan will be developed and		
		breathing treatments and			implemented. Monthly QAPI		
	when finished pl	laced tubing and	I		minutes and action plans are		I

PRINTED: 07/26/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155511		r í	ILDING	nstruction <u>00</u>	(X3) DATE ( COMPL <b>06/13</b> /	ETED	
	PROVIDER OR SUPPLIER	ND REHABILITATION CENTER		830 S 6	DDRESS, CITY, STATE, ZIP CODE TH ST HAUTE, IN 47807		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	did not place the bag because it w	edside table, indicated he mouthpiece back into as too much trouble and clean the equipment after			submitted to regional operations staff and corporate risk management for review.  Date Completed: July 3, 2017		
	During an intervent p.m., the DON in cleans the nebuliand should place bag once the nebuliand should place bag once the nebuliand should place bag once the nebuliand should place be resident did not.  On 6/12/17 at 1: (Director of Nuradocument titled, Medication There indicated the polibeing used by the indicated, " 17 the nebulizer equivith patient name the nebulizer equivity patient name the nebulizer equipocumentation is medication left in and dried after each should be nebuliand the nebuliand the nebuliand the nebuliand should be nebuliand the nebul	"Aerosolized apy Education," and icy was the one currently e facility. The policy. When finished, place aipment in a labeled bag e and date. 18. Change aipment weekly should include: In cup needs poured out each treatment"					
	provided a docur Treatments," and	12 p.m., the DON ment titled, "Aerosol I indicated the policy was being used by the					

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

Event ID:

VKEC11 Facility ID: 000446

If continuation sheet

Page 71 of 77

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		ILDING	00	COMPL	
		155511	B. WI	NG		06/13/	2017
	ROVIDER OR SUPPLIER	ND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE  830 S 6TH ST  TERRE HAUTE, IN 47807				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	(X5) COMPLETION DATE
F 9999	B. Nebulizers after each use and	cy indicated, " Policy: are to be shaken dry d stored aseptically. C. including masks are to tly and prn (as					
Bldg. 00	required for each within one (1) memployment. The include a tuberous Mantoux method administered by a documentation of department-approximatruction in interesting, reading, a previously positif documented. The	amination shall be a employee of a facility onth prior to be examination shall ulin skin test, using the l (5 TU PPD), persons having f training from a oved course of radermal tuberculin skin and recording unless a ve reaction can be be result shall be recorded finduration with the date	F 99	999	F999 FINAL OBSERVATIONS  3.1-14(t)(1) PERSONEL  A physical examination shall be required for each employee at a facility within one month prior to employment. The examination shall include tuberculin skin test, using the Mantoux method (5 TU PPD), administered by persons having documentation of training from a department approved course of instruction in intradermal tuberculin skin testing, reading, and recording unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given,		07/13/2017
	administered. The must be read price	the tuberculin skin test or to the employee he facility must assure			date read, and by whom administered. The tuberculin skin test must be read prior to the employee starting work. The facility must assure the following: At time	,	

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

Event ID:

VKEC11 Facility ID: 000446

If continuation sheet Page 72 of 77

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING 00		00	COMPLETED		
		155511	B. WING		06/13/2017			
				CTDEET /	ADDRESS, CITY, STATE, ZIP CODE			
NAME OF PROVIDER OR SUPPLIER								
TERRE HAUTE NURSING AND REHABILITATION CENTER				830 S 6TH ST TERRE HAUTE, IN 47807				
IERREI	TAUTE NURSING F	AND REHABILITATION CENTER		IERRE	HAUTE, IN 47607			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)			TAG	DEFICIENCY)		DATE	
	(1) At the time of	of employment, or within		of employment, or within or month prior to employment				
	one (1) month p	rior to employment, and				at		
	at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. For health care workers who have not had a				least annually thereafter,			
					employees and nonpaid personne			
					of the facility shall be screened for	ſ		
					tuberculosis. For health care			
					workers who have not had a			
	_	ative tuberculin skin test			documented negative tuberculin			
		preceding twelve (12)			skin test result during the precedir twelve months, the baseline	ig		
	months, the base	eline tuberculin skin			tuberculin skin testing should			
	testing should employ the two-step				employ the two step method. If th	۵.		
	method. If the first step is negative, a				first step is negative, a second test			
	second test should be performed one (1)				should be performed on to three			
	to three (3) weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis.				weeks after the first step. The			
					frequency of repeat testing will			
					depend on the risk of infection wit	th		
					tuberculosis.			
	This state rule was not met as evidenced				1. How will the corrective action			
	by:				be accomplished for those			
					residents who are affected by this			
	Based on record	review and interview,			alleged deficient practice?			
		d to ensure 6 of 10						
	employees had a health review conducted by the Director of Nursing (DON) or Registered Nurse (RN) designee, and				-The DON/RN Designee will monito	or,		
					document and sign all employee			
					physical examinations.			
	_				-The DON/RN Designee will monito	ar.		
	failed to ensure 3 out of 10 employees had tuberculosis (TB) screening upon				all employee tuberculin skin testing			
					to ensure compliance.			
	hire. This defici	ency had the potential to			to choose compliance.			
	affect 23 out of 23 residents residing at the facility.  Findings include:				2. How will the facility identify			
					residents having the potential to b	e		
					affected by the same deficient			
					practice?			
	i maniga merude							
	0 (10/17 + 2.00				-All residents in the facility			
		00 p.m., ten employee			could potentially be affected by thi	S		
	records were reviewed for proof of				practice. However, the DON/RN			

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION		IDENTIFICATION NUMBER:	A. BUILDING <u>00</u>		00	COMPLETED	
155511		B. WING			06/13/2017		
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER				830 S 6			
TERRE HAUTE NURSING AND REHABILITATION CENTER					HAUTE, IN 47807		
			1				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)	
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE COMPLETION DATE	
TAG		· · · · · · · · · · · · · · · · · · ·		IAU	·		
	1 1	ation and tuberculosis			Designee will be monitor, document and sign all employee physicals.	•	
	` ′	ipon hire. Six employee			DON/RN Designee will be		
		red Nurses (RN 5, 4),			responsible for monitoring all		
	Licensed Practic	al Nurse (LPN 6) and			employee tuberculin skin testing.		
	Certified Nurse Aides (CNA 1, 2, 3),				employee tabel camil sum testing.		
	failed to show do	ocumentation of physical			3. What measures were put into		
		on hire. Three employee			place or systemic changes made to		
	_	, 2, 3), failed to show			ensure the deficient practice will		
		of TB screening upon			not recur?		
		of 1D screening upon					
	hire.				- Implemented on 6/19/17 DON/RN		
					Designee will monitor, document		
	State form 5440, "Employee Records",				and sign all employee physical		
	provided on 6/7/17 at 2:00 p.m. by the				examinations. Once physical		
	Administrator, indicated RN 5 began				examination is signed by DON/RN		
	employment on 1/26/17, RN 6 began				Designee, it will then be given the Business Office Manager to file in		
	employment on 3/5/16, LPN 6 began				the respective employees' file.		
	employment on 10/7/16, CNA 1 began				the respective employees me.		
	employment on 2/24/17, CNA 3 began				-DON/RN Designee will maintain an	d	
	employment on 2/9/17, CNA 7 began				monitor all employee's tuberculin		
					skin test until completion. Once		
	employment on 4/6/17, and CNA 2 began				tuberculin skin test are completed,		
	employment on 3/18/17.  1. RN 5, had a Post-Offer Pre-Employment Physical completed and				DON/RN Designee will give those		
					results to Business Office Manager		
					to file in the respective employee's		
					file		
	signed by LPN 9	) <sub>.</sub>	1		A Hammillaha fasilisa masik		
					4. How will the facility monitor its corrective action?		
	RN 4, had a Pos	t-Offer Pre-Employment			corrective actions		
	· ·	ted and signed by LPN 8.			-The DON/RN Designee is		
	Thysical completed and signed by Li iv 6.				responsible for monitoring and		
	LPN 6, had a Post-Offer Pre-Employment Physical completed and				signing all physicals, including but		
					not limited to tuberculin skin test		
	1	-			results QAPI audits weekly for four		
	signed by LPN 8	5.	1		weeks and monthly for six months		
					thereafter until compliance is		
	CNA 1, had a Post-Offer				maintained for two consecutive		

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

Event ID:

VKEC11 Facility ID: 000446

If continuation sheet Page 74 of 77

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X1) PROVIDER/SUPPLIER/SU		(X2) MUL' A. BUIL B. WINC	DING	NSTRUCTION  00	(X3) DATE ( COMPL <b>06/13</b> /	ETED	
NAME OF PROVIDER OR SUPPLIER TERRE HAUTE NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE  830 S 6TH ST  TERRE HAUTE, IN 47807				
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PR	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΤE	(X5) COMPLETION DATE
	Pre-Employment signed by LPN 1  CNA3, had a Post Physical complet 10.  CNA 7, had a Post Pre-Employment signed by LPN 1  2. CNA 1, was a TB skin test on 2 step	the Physical completed and the physical completed and the strength of the stre			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 operation staff and corporate risk management team for review.  Date Completed: July 3, 2017		
I	(BOM) is responsible for keeping employee files current.						

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

Event ID:

VKEC11 Facility ID: 000446

If continuation sheet

Page 75 of 77

PRINTED: 07/26/2017 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155511		A. BUILDING B. WING	<u>00</u>	COMPLETED 06/13/2017			
NAME OF PROVIDER OR SUPPLIER  TERRE HAUTE NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE  830 S 6TH ST  TERRE HAUTE, IN 47807					
(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 APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE			
	On 6/12/17 at 1:20 p.m., during an interview with the DON, Administrator and Regional Clinical Director, the DON and Administrator indicated that LPN's had completed the Post-Offer Pre-Employment Physical form and it should have been a RN. The Regional Clinical Director agreed and indicated they cannot fix the past.  On 6/12/17 at 10:45 a.m., the Regional BOM, indicated employees have not been sent out for pre-employment physicals. The "Post-Offer Pre-Employment Physical" is being utilized. 2-step TB skin results are kept in the employee file and in a binder at the desk.  The DON, on 06/12/17 at 10:35 a.m., provided a current policy titled, "Human Resources Policies and Procedures Manual; Section 1. Employment; Subject, HR-106: Health Requirements Revised 4/15/15". The Health Review indicated: "The DON or RN designee will conduct the health review to include the TB test, vital sign assessment, and ability to perform the essential functions of the job"  The Regional Clinical Director, on 6/12/17 at 11:00 a.m., provided a duplicate of the "Human Resources						

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

Event ID:

VKEC11 Facility ID: 000446

If continuation sheet Page 76 of 77

PRINTED: 07/26/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE	SURVEY		
l í		IDENTIFICATION NUMBER:	A. BUILDING 00		COMP	COMPLETED	
155511		B. WING		06/13	3/2017		
			STREE	ET ADDRESS, CITY, STATE, ZIP CO	DE		
NAME OF PROVIDER OR SUPPLIER			S 6TH ST	J.E			
TERRE H	HAUTE NURSING A	AND REHABILITATION CENTER		RE HAUTE, IN 47807			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRE	CTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE		
	Policies and Procedures Manual; Section						
	1. Employment;	Subject, HR-106: Health					
	Requirements R	evised 4/15/15" and					
	indicated this is	the most current policy.					
	Health Review indicates: "The DON or						
	RN designee wil	ll conduct the health					
	_	e the TB test, vital sign					
	assessment, and ability to perform the						
	essential functions of the job".						
	essential fametro	is of the job.					
	On 6/12/17 at 11	·00 a m the Pegional					
	On 6/12/17 at 11:00 a.m., the Regional						
	Clinical Director provided a current						
	policy, "Infection Prevention Manual for						
	Long Term Care" and indicated this is						
	used for TB skin testing. The policy						
	indicates, " All qualified applicants for						
	employment shall be screened for						
	presence of infection with M.						
	tuberculosis usir	ng the Mantoux TST.					
	Skin testing will employ the two-step						
	procedure"						
	1						
	3.1-14(t)(1)						
	J.1-1 <del>-1</del> (t)(1)						

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

Event ID:

VKEC11 Facility ID: 000446

If continuation sheet Page 77 of 77