STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155468	A. BUILDING 00 B. WING	08/29/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRECKENRIDGE HEALTH & REHABILITATION	325 W NORTHWOOD DR SULLIVAN, IN 47882

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: July 22, 23, 24, 25, 28 and 29, 2017 Facility number: 000525 Provider number: 155468 AIM number: 100267010 Census Bed Type: SNF/NF: 31 SNF: 0 NF: 0 Total: 31 Census Payor Type: Medicare: 5 Medicaid: 24 Other: 2 Total: 31 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on September 6, 2017.	F 0000	Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. The plan of correction is prepared and submitted because of requirement under state and federal law. Please accept this plan of correction as our credible allegation of compliance. Please find enclosed this plan of correction for this survey. Due to the low scope and severity of the survey findings, please find the sufficient documentation providing evidence of compliance with the plan of correction. The documentation serves to confirm the facility's allegation of compliance. Thus, the facility respectfully requests the granting of paper compliance. Should additional information be necessary to confirm said compliance, feel free to contact me.	
F 0242 SS=D Bldg. 00	483.10(f)(1)-(3) SELF-DETERMINATION - RIGHT TO MAKE CHOICES			

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155468	A. BUILDING 00 B. WING	08/29/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRECKENRIDGE HEALTH & REHABILITATION	325 W NORTHWOOD DR SULLIVAN, IN 47882

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. (f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. (f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. Based on interview and record review, the facility failed to ensure a resident's preferences for customary routines for getting out of bed were honored for 1 of 28 residents reviewed for choices (Resident 6). Findings include: During a resident interview, on 8/23/17 at 9:09 a.m., Resident 6 indicated she did not get to choose when she got up in the morning. Staff get her up early and she would often have to sit and wait before breakfast was served. No one had ever asked her what time she preferred to get up in the morning. Resident 6's record was reviewed on 8/24/17 at 8:35 a.m., a quarterly MDS (minimum data set) assessment, dated 5/10/17, indicated the resident had	F 0242	F242 Requires the facility to ensure a resident's preference for customary routines for getting out of bed is honored. 1. Resident #6 was interviewed regarding her preferences and the plan of care updated. 2. All residents have the potential to be affected. All residents were interviewed regarding care and the plan of care updated as needed. No concerns were noted. Resident Daily Preferences care plans will be reviewed at least quarterly and with any changes ongoing. See below for corrective measures. 3. As a means to ensure ongoing compliance, the Resident Rights policy and procedure was reviewed with no changes made. (See attachment A) The staff was inserviced on the above procedure to ensure knowledge of following resident daily preferences.	09/14/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155468	A. BUILDING 00 B. WING	08/29/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRECKENRIDGE HEALTH & REHABILITATION	325 W NORTHWOOD DR SULLIVAN, IN 47882

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	moderate cognitive deficit. A document titled, "Daily Preference Care Plan," dated 4/14/17 and reviewed on 7/21/17, did not address the resident's preference for preferred wake time. During an interview, on 8/24/17 at 11:24 a.m., the Corporate Social Service Consultant indicated resident preferences were documented on the daily preferences care plan for each resident. The care plan would be updated each time the care plan was reviewed or if the resident's preference had changed. The daily preference care plan for Resident 6's preferred wake time had not been documented on the care plan and was likely overlooked. On 8/24/17 at 11:37 a.m., the Corporate Social Service Consultant provided a document, revised 11/28/16, titled, "Resident Rights," and indicated the policy was the one currently being used by the facility. The document indicated, "Resident Rights: The resident has a right to...self-determination...and services inside...the facility...." 3.1-3(u)(1)		4. As a means of quality assurance, the DON or his designee will interview two residents a day to ensure that their preferences are being followed per plan of care. The DON or her designee will utilize the nursing monitoring tool daily times four weeks, then weekly times four weeks, then every two weeks times two months, then quarterly thereafter until 100% compliance is obtained and maintained for 2 consecutive quarters. (See attachment B) The audits will be reviewed during the facility's quarterly quality assurance meetings and the plan of correction will be adjusted accordingly. 5. The above corrective measures will be completed on or before September 14, 2017.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155468	A. BUILDING 00 B. WING	08/29/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRECKENRIDGE HEALTH & REHABILITATION	325 W NORTHWOOD DR SULLIVAN, IN 47882

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0280 SS=D Bldg. 00	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. (c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must-- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155468	A. BUILDING 00 B. WING	08/29/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRECKENRIDGE HEALTH & REHABILITATION	325 W NORTHWOOD DR SULLIVAN, IN 47882

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	care. 483.21 (b) Comprehensive Care Plans (2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155468	A. BUILDING 00 B. WING	08/29/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRECKENRIDGE HEALTH & REHABILITATION	325 W NORTHWOOD DR SULLIVAN, IN 47882

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Based on record review, and interview, the facility failed to ensure care plans were revised for 1 of 25 resident care plans reviewed (Residents 38). Findings include: Resident 38's record was reviewed on 8/24/17 at 9:06 a.m. The physicians orders indicated, but was not limited to, diagnosis of chronic kidney disease. A care plan, initiated on 12/19/15 and updated on 10/4/16, included but was not limited to, Chronic Real Failure (CKD); Resident had diagnosis of chronic kidney disease and was at risk for complications associated with chronic kidney disease. Interventions included a 1500 cc (milliliters) fluid restriction. A review of Physician's orders included, but was not limited to, a regular diet with no sugar packets, NAS (no added salt) with thin liquids. During an interview on 8/24/17 at 11:46 a.m., the Corporate Nurse Consultant indicated the DON (Director of Nursing) or ADON (Assistant Director of Nursing) would update care plans as new orders were received. Also indicated Resident 38 was not on a 1500 cc fluid restriction at this time and the care plan should have	F 0280	F280 Requires the facility to ensure care plans are revised. 1. Resident 38 care plan was reviewed and updated. 2. All residents have the potential to be affected. All resident's care plans were reviewed and updated. See below for corrective measures. 3. As a means to ensure ongoing compliance, the Care Plan Development and Review policy and procedure was reviewed with no changes made. (See attachment C) The staff was inserviced on the on the above procedure. 4. As a means of quality assurance, the DON or his designee will, daily on scheduled days of work, update applicable care plans based upon changes reflected in newly obtained orders. The DON or his designee will review two care plans a day ensuring that they are revised with any change of care. The DON or his designee will utilize the nursing monitoring tool daily times four weeks, then weekly times four weeks, then every two weeks times two months, then quarterly thereafter until 100% compliance is obtained and maintained for 2 consecutive quarters. (See attachment B) The audits will be reviewed during the facility's quarterly quality assurance meetings and the plan of correction will be adjusted accordingly. 5. The above corrective	09/14/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155468	A. BUILDING 00 B. WING	08/29/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRECKENRIDGE HEALTH & REHABILITATION	325 W NORTHWOOD DR SULLIVAN, IN 47882

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	been updated when the fluid restriction was discontinued. On 8/24/17 at 11:37 a.m., the Corporate Social Services Director provided a document titled, "Care Plan Development and Review Procedure," and indicated the policy was the one currently being used by the facility. The policy indicated, "Purpose: To assure that a comprehensive care plan for each resident includes measurable objectives and timetables to meet the resident's medical and psychosocial needs. Policy: ... 4. Care plans are revised as changes in the resident's condition dictate. Changes in the resident's care or condition must be addressed on the care plan (i.e. physician's orders, diet changes ...)...." 3.1-35(b)(1)		measures will be completed on or before September 14, 2017.	
F 0282 SS=D Bldg. 00	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. Based on record review and interview,	F 0282	F282 Requires the facility to	09/14/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155468	A. BUILDING 00 B. WING	08/29/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRECKENRIDGE HEALTH & REHABILITATION	325 W NORTHWOOD DR SULLIVAN, IN 47882

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	the facility failed to follow physician's orders for administering insulin (Resident 38) and changing a urinary catheter (Resident 26) for 2 of 25 resident's reviewed for following physicians orders. Findings include: 1. Resident 38's record was reviewed on 8/24/17 at 9:06 a.m. The physicians orders indicated, but was not limited to, diagnosis of diabetes mellitus II. A care plan, initiated on 10/25/16 and updated on 7/4/17, included but was not limited to, Diabetes; Resident with diagnosis of diabetes mellitus and was at risk for hyperglycemia and/or hypoglycemia. Interventions included administer medications as ordered. A review of Physician's orders initiated 3/7/17 included, but was not limited to, Lantus (insulin) 100 units/mL (milliliters) vial inject 20 units sub-q (subcutaneous) every day for diagnosis of diabetes mellitus. A review of the MAR (medication administration record) charted for 6/1/17 through 6/30/17 indicated the resident did not receive Lantus on 6/7/17, 6/9/17, 6/16/17, 6/17/17, and 6/18/17.		follow physician's orders for administering insulin and changing catheters. 1. Resident #38 insulin order was reviewed and insulin is to be given per order. Resident catheter order was reviewed and the catheter to be changed per order. 2. All residents have the potential to be affected. All resident insulin and catheter orders were reviewed and staff to provide care per the physician orders. No concerns were noted. See below for corrective measures. 3. As a means to ensure ongoing compliance, the Physician Orders policy and procedure was reviewed with no changes made. (See attachment D) The staff was inserviced on the above procedure to ensure knowledge regarding adherence to all physician orders. 4. As a means of quality assurance, the DON or his designee will monitor the medication and treatment records to ensure insulin and catheters are changed per the physician. The DON or his designee will utilize the nursing monitoring tool daily times four weeks, then weekly times four weeks, then every two weeks times two months, then quarterly thereafter until 100% compliance is obtained and maintained for 2 consecutive quarters, (See attachment B) The audits will be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155468	A. BUILDING 00 B. WING	08/29/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRECKENRIDGE HEALTH & REHABILITATION	325 W NORTHWOOD DR SULLIVAN, IN 47882

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	A review of the MAR charted for 7/1/17 through 7/31/16 indicated the resident did not receive Lantus on 7/7/17, 7/ 13/17, 7/19/17, 7/20/17, 7/21/17, and 7/28/17. During an interview on 8/24/17 at 11:46 a.m., the Corporate Nurse Consultant indicated when a medication was administered the nurse assigned to the resident signed their initials on the MAR. 2. Resident 26's record was reviewed on 8/28/17 at 10:41 a.m. The MAR (medication administration record), dated August 2017, indicated the resident's diagnoses included, but were not limited to, neurogenic bladder. An annual MDS (minimum data set) assessment, dated 2/25/17, indicated the resident had an Foley (indwelling urinary) catheter. A care plan, dated 3/6/17, and reviewed on 6/14/17, indicated the resident required use of a Foley catheter related to neurogenic bladder. The resident's TAR (treatment administration record), dated August 2017, indicated a physician's order to change the Foley catheter and drainage bag monthly on the 16th and as needed on the 10:00 p.m., to 6:00 a.m., shift. The document indicated the nurse's initials on		reviewed during the facility's quarterly quality assurance meetings and the plan of correction will be adjusted accordingly. 5. The above corrective measures will be completed on or before September 14, 2017.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155468	A. BUILDING 00 B. WING	08/29/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRECKENRIDGE HEALTH & REHABILITATION	325 W NORTHWOOD DR SULLIVAN, IN 47882

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	the 16th had been circled. During an interview, on 8/28/17 at 12:11 p,m., RN 4 indicated the circled initials on the TAR meant the procedure had not been completed and the catheter had not been changed as ordered. On 8/28/17 at 2:36 p.m., the Corporate Nurse Consultant provided a document, dated 10/2014, titled, "Physician Orders," and indicated the policy was the one currently being used by the facility. The document indicated, "...Procedure: ...5. Transcribe order...as indicated. Ensure any follow through is completed...." 3.1-35(g)(2)			
F 0332 SS=D Bldg. 00	483.45(f)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE (f) Medication Errors. The facility must ensure that its- (1) Medication error rates are not 5 percent or greater; Based on observation, record review, and interview, the facility failed to ensure a medication error rate of less than 5% (percent)observed during 3 of 37 opportunities for errors during random medication administration observations,	F 0332	F332 Requires the facility to ensure a medication error rate of less than 5%. 1. Resident 33 and 44 physician orders were reviewed. 2. All residents have the potential to be affected. Nurses were educated on giving insulin	09/14/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155468	A. BUILDING 00 B. WING	08/29/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRECKENRIDGE HEALTH & REHABILITATION	325 W NORTHWOOD DR SULLIVAN, IN 47882

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	resulting in a medication error rate of 8.1% (Residents 44 and 23). Findings include: 1. During a random medication administration observation on 8/24/17, at 12:00 p.m., Licensed Practical Nurse (LPN) 6 administered Humalog (a rapid acting insulin) 100 units (u)/milliliter (ml), 9 units subcutaneously (an injection between the skin and muscle) to Resident 44. On 8/24/17, at 12:19 p.m., Resident 44's lunch was served. Resident 44's record was reviewed on 8/25/17, at 9:34 a.m. A physician's order, dated 6/1/17, indicated Humalog 100 u/ml, inject per sliding scale. A Humalog medication information sheet was provided by Registered Nurse (RN) 4 on 8/24/17, at 2:57 p.m., and she indicated it was the policy currently being used by the facility. The policy indicated, "...Humalog starts acting fast, so inject it up to 15 minutes before or right after you eat a meal...." 2. During a random medication administration observation on 8/24/17, at 12:05 p.m., LPN 6 administered Novolog		and sucralfate at recommended times. See below for corrective measures. 3. The Medication Administration policy and procedure was reviewed with no changes made. (See attachment E) The staff was inserviced on the on the above procedure to ensure adherence to the Medication Administration policy 4. The DON or his designee will review monitor one medication pass a day ensuring medication is given at appropriate times. The DON or his designee will utilize the nursing monitoring tool daily times for weeks, then weekly times four weeks, then every two weeks times two months, then quarterly thereafter until 100% compliance is obtained and maintained for 2 consecutive quarters. (See attachment B) The audits will be reviewed during the facility's quarterly quality assurance meetings and the plan of correction will be adjusted accordingly. 5. The above corrective measures will be completed on or before September 14, 2017.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155468	A. BUILDING 00 B. WING	08/29/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRECKENRIDGE HEALTH & REHABILITATION	325 W NORTHWOOD DR SULLIVAN, IN 47882

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	(a fast acting insulin) 100 u/ml, 15 units subcutaneously to Resident 23. On 8/24/17, at 12:27 p.m., Resident 23's lunch was served. Resident 23's record was reviewed on 8/25/17, at 1:44 p.m. A physician's order, dated 3/22/17, indicated Novolog 100 u/ml, inject 15 u subcutaneously before meals. During an interview on 8/25/17, at 9:30 a.m., the Director of Nursing (DON) indicated the insulin should not have been given more than 5-10 minutes before a meal was served. A Novolog medication information sheet was provided by RN 4 on 8/24/17, at 2:57 p.m., and she indicated it was the policy currently being used by the facility. The policy indicated, "...Inject subcutaneously within 5-10 minutes before a meal...." 3. During a random medication administration observation on 8/25/17, at 8:00 a.m., LPN 6 administered sucralfate (Carafate, an antacid) 1 gram (gm) by mouth to Resident 44. It was observed during the medication administration observation that Resident 44 had already eaten breakfast. An empty breakfast			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155468	A. BUILDING 00 B. WING	08/29/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRECKENRIDGE HEALTH & REHABILITATION	325 W NORTHWOOD DR SULLIVAN, IN 47882

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	plate was observed in front of Resident 44. Resident 44's record was reviewed on 8/25/17, at 9:34 a.m. A physician's order, dated 6/1/17, indicated sucralfate 1 gm tablet, by mouth, before meals, and at bedtime. During an interview on 8/25/17, at 9:30 a.m., the DON indicated the sucralfate should not have been administered after Resident 44 had eaten. On 8/25/17, at 10:27 a.m., the Administrator provided a document titled, "Medication Administration," and indicated it was the policy currently being used by the facility. The policy indicated, "PURPOSE: To safely administer medications as per physicians' orders. POLICY: Licensed or qualified personnel shall be responsible to follow accepted practices of medication administration as per physicians' orders...TIME ELEMENT...2. Medications ordered ac [before meals] or pc [after meals] are to be given approximately 1/2 hour before (ac) or after (pc) the meal...4. Food causes some medications to lose effectiveness, therefore, these medications should be given on an empty stomach. Be mindful of any specific instructions provided by the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155468	A. BUILDING 00 B. WING	08/29/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRECKENRIDGE HEALTH & REHABILITATION	325 W NORTHWOOD DR SULLIVAN, IN 47882

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	pharmacy...GUIDELINES FOR MEDICATION ADMINISTRATION: 1. Medications are administered to residents only as prescribed and only by person licensed or qualified to do so...." 3.1-25(b)(9)			