

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155230	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	(X3) DATE SURVEY COMPLETED 08/29/2017
NAME OF PROVIDER OR SUPPLIER ROSEBUD VILLAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 2050 CHESTER BLVD RICHMOND, IN 47374		
(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	<p>This visit was for the Investigation of Complaints IN00235511, IN00236074 and IN00237771.</p> <p>Complaint IN00235511 - Substantiated. No deficiencies related to the allegations are cited.</p> <p>Complaint IN00236074 - Substantiated. Federal/State deficiencies related to the allegations are cited at F282 and F514.</p> <p>Complaint IN00237771 - Substantiated. Federal/State deficiencies related to the allegations are cited at F282 and F514.</p> <p>Survey dates: August 24, 25, 28 and 29, 2017</p> <p>Facility number: 000135 Provider number: 155230 AIM number: 100266820</p> <p>Census Bed Type: SNF/NF: 89 SNF: 7 Total: 96</p> <p>Census Payor Type: Medicare: 14 Medicaid: 61</p>	F 0000		

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

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155230	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	(X3) DATE SURVEY COMPLETED 08/29/2017
NAME OF PROVIDER OR SUPPLIER ROSEBUD VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 2050 CHESTER BLVD RICHMOND, IN 47374	
(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)
F 0282 SS=D Bldg. 00	<p>Other: 21 Total: 96</p> <p>These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed on August 31, 2017</p> <p>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-</p> <p>(ii) Be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on interview and record review, the facility failed to follow physician orders in regards to a stop date for the use of an antibiotic and administer narcotic pain medication as ordered for 3 of 4 residents reviewed for medication administration. (Resident B, C, and D)</p>		F 0282	<p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>Resident D was assessed by a licensed nurse, with no adverse effects noted. MD and family notified. MD order placed for ATB end date.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155230	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 08/29/2017
NAME OF PROVIDER OR SUPPLIER ROSEBUD VILLAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 2050 CHESTER BLVD RICHMOND, IN 47374		
(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
	<p>Findings include:</p> <p>1. The clinical record for Resident C was reviewed on 8/28/17 at 11:07 a.m. The diagnoses included, but were not limited to, Alzheimer's dementia, scrotal discomfort, and venous stasis ulcer of right lower extremity.</p> <p>Resident C had the following physician order, "...Tylenol #3 with codeine every 4 hours...Dx: [diagnosis] pain...." The order was dated 8/25/17. Prior to that, Resident C had an order for Tylenol #3 with codeine, one tablet four times a day that was dated for 8/17/17.</p> <p>The controlled substance record for Resident C noted the following date/time(s) the Tylenol #3 with codeine was administered:</p> <p>8/22/17 at 6:00 a.m., 8/22/17 at 6:00 p.m., 8/25/17 at 6:00 p.m., 8/26/17 at 2:00 a.m., 8/26/17 at 10:00 a.m., & 8/26/17 at 2:00 p.m.</p> <p>The Medication Administration Record (MAR) for Resident C noted the dose on 8/22/17 at 12:00 p.m. was left blank, indicating it wasn't given. The MAR</p>		<p>Resident C was assessed by a licensed nurse, with no adverse effects noted. No pain or discomfort voiced. MD and family notified. No new orders.</p> <p>Resident B no longer resides in this facility</p> <p>Disciplinary action taken for the two nurses responsible for the deficient practices. Medication Error Reports were completed as indicated. Both nurses no longer work in this facility at this time.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?</p> <p>All residents with orders for Antibiotics or Narcotic medications have the potential to be effected by this alleged deficient practice. DNS/ designee will conduct an audit of all Narcotic Logs and MD orders to identify any other residents to be affected by 9/22/17. DNS/designee will audit all ATB orders by 9/22/17 to ensure end dates are present as indicated. Any resident found to be effected will be assessed for adverse effects, MD and family will be notified as indicated, and new orders will be obtained as indicated.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155230	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 08/29/2017
NAME OF PROVIDER OR SUPPLIER ROSEBUD VILLAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 2050 CHESTER BLVD RICHMOND, IN 47374		
(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
	<p>shows the last dose of the Tylenol #3 with codeine to administer four times a day was last given on 8/25/17 at 6:00 p.m.</p> <p>The MAR indicated the Tylenol #3 with codeine, give every 4 hours scheduled, was left blank for 8/25/17 at 10:00 p.m. and 8/26/17 at 6:00 a.m.</p> <p>On 8/29/17 at 8:40 a.m., an interview was conducted with the Director of Nursing Services (DNS). She indicated she was unable to find a reason as to why Resident C didn't receive the Tylenol #3 with codeine on 8/22/17 at 12:00 p.m., 8/25/17 at 10:00 p.m., and 8/26/17 at 6:00 a.m.</p> <p>2. The clinical record for Resident D was reviewed on 8/28/17 at 11:00 a.m. The diagnoses included, but were not limited to, pneumonia, sepsis, and infection of urinary tract.</p> <p>Resident D was sent to the hospital on 8/10/17 and readmitted to the facility on 8/14/17.</p> <p>There were two scripts from the hospital, dated 8/14/17, that indicated the following orders:</p> <p>"nitrofurantoin monohyd/m-cryst</p>		<p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</p> <p>Nurses will be re-educated on obtaining end dates for ATBs when indicated by 9/22/17 by DNS/designee. Nurses will be re-educated on passing medications as ordered by 9/22/17 by DNS or designee. Nurses will be re-educated on removing all discontinued medications from nurse's carts timely by 9/22/17 by DNS/designee. DNS/designee will notify MD of any new order for an Antibiotic without an end date and obtain one when indicated. IDT will review Narcotic Logs daily to ensure Narcotics have been administered as ordered.</p> <p>How will the corrective actions be maintained to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <p>To ensure compliance, the DNS/designee is responsible for the completion of the Medication Administration QAPI tool weekly x 4 weeks, monthly x 6 months, and then quarterly until continued compliance is maintained for two consecutive quarters. The results of these audits will be reviewed during monthly QAPI meeting, overseen by the ED. If the threshold of 95% is not</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155230	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	(X3) DATE SURVEY COMPLETED 08/29/2017
NAME OF PROVIDER OR SUPPLIER ROSEBUD VILLAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 2050 CHESTER BLVD RICHMOND, IN 47374		
(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
	<p>[antibacterial agent for urinary tract infections] 100 mg [milligrams] Capsule...1 capsule oral twice a day with or without food x [times] 5 days...."</p> <p>"metronidazole [antibiotic] 500 mg tablet...1 tablet oral three times a day with or after food x 7 days for C Diff [Clostridium difficile, is a bacterium that can cause symptoms ranging from diarrhea to life-threatening inflammation of the colon]...."</p> <p>The August, 2017 MAR for Resident D indicated the metronidazole was given for 20 doses after the 7 day stop date.</p> <p>The August, 2017 MAR for Resident D indicated the nitrofurantoin capsule for 3 doses after the 5 day stop date.</p> <p>An interview was conducted with the Director of Nursing Services (DNS) on 8/28/17 at 3:44 p.m. She indicated the nitrofurantoin was given for 3 doses after the stop date and the metronidazole should have been stopped after 7 days per the instructions on the script from the hospital. Her expectations are for medications to be stopped when there is a stop date and for nursing staff to follow physician orders as written. She indicated there was no policy for following physician orders.</p>		achieved an action plan will be developed to ensure compliance and disciplinary action taken as needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155230	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 08/29/2017	
NAME OF PROVIDER OR SUPPLIER ROSEBUD VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 2050 CHESTER BLVD RICHMOND, IN 47374		
(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
	<p>3. The clinical record for Resident B was reviewed on 8/28/17 at 11:15 a.m. The diagnoses included, but were not limited to, anxiety, hairy cell leukemia, and dementia.</p> <p>A written physician order, dated 7/24/17, indicated the following, "...Fentanyl transdermal patch 12 mcg/h [micrograms an hour]...apply 1 patch Q3 [every 3 days....]"</p> <p>Another written physician order, dated 7/28/17, indicated the following, "...Fentanyl 25 mcg [micrograms] patch...1 topically Q [every] 72 [symbol for hours]...."</p> <p>The narcotic log for the 12 mcg Fentanyl patch indicated it was administered on 7/28/17 and 7/31/17.</p> <p>A lined piece of notebook paper, noted with Resident B's name and date of birth, dated 7/28/17, indicated the following, "...new order 7/28/17...Fentanyl 25 mcg/hr [micrograms an hour] patch one patch [sic] change Q [every] 72 hours...." The patch was signed off as being administered on 7/28/17 and 8/3/17 but not for 7/31/17.</p> <p>It appears that Resident B received both</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155230	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 08/29/2017
NAME OF PROVIDER OR SUPPLIER ROSEBUD VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 2050 CHESTER BLVD RICHMOND, IN 47374	
(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)
	<p>Fentanyl 12 mcg and 25 mcg patch on 7/28/17. Resident B also received Fentanyl 12 mcg patch on 7/31/17 after it was changed to 25 mcg on 7/25/17.</p> <p>On 8/29/17 at 5:25 p.m., an interview was conducted with the Director of Nursing Services (DNS). She indicated the Fentanyl 12 mcg patch was not marked off as discontinued on the Medication Administration Record (MAR) for Resident B. That resulted in a medication error of the 12 mcg and the 25 mcg patch being signed off as given. Her expectations are for the nursing staff to cross out and mark discontinued and place the new order on the MAR.</p> <p>A policy titled "Medication Pass Procedure", review date of 12/2016, was provided by the DNS on 8/29/17 at 10:44 a.m. The policy indicated the following, "...Procedure steps:...6. Perform the 5 rights of medication...Right Resident...Right Medication...Right dose...Right route...Right time...."</p> <p>This Federal tag relates to Complaints IN00236074 and IN00237771.</p> <p>3.1-35(g)(2)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155230	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 08/29/2017	
NAME OF PROVIDER OR SUPPLIER ROSEBUD VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 2050 CHESTER BLVD RICHMOND, IN 47374		
(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 0514 SS=D Bldg. 00	<p>483.70(i)(1)(5) RES RECORDS-COMPLETE/ACCURATE/ACCE SSIBLE</p> <p>(i) Medical records. (1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-</p> <ul style="list-style-type: none"> (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized <p>(5) The medical record must contain-</p> <ul style="list-style-type: none"> (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other 				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155230	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 08/29/2017
NAME OF PROVIDER OR SUPPLIER ROSEBUD VILLAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 2050 CHESTER BLVD RICHMOND, IN 47374		
(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
	<p>diagnostic services reports as required under §483.50.</p> <p>Based on interview and record review, the facility failed to ensure the documentation of medication administration records (MARs), treatment administration records (TARs), narcotic logs, and wound assessments were complete and accurate for 3 of 4 residents reviewed for medication administration and 2 of 3 residents reviewed for skin conditions. (Resident B, Resident C, and Resident D)</p> <p>Findings include:</p> <p>1a. The clinical record for Resident B was reviewed on 8/28/17 at 11:15 a.m. The diagnoses included, but were not limited to, anxiety, hairy cell leukemia, and dementia.</p> <p>A written physician order, dated 7/24/17, indicated the following, "...Fentanyl transdermal patch 12 mcg/h [micrograms an hour]...apply 1 patch Q3 [every 3 days....]"</p> <p>Another written physician order, dated 7/28/17, indicated the following, "...Fentanyl 25 mcg [micrograms] patch...1 topically Q [every] 72 [symbol for hours]...."</p>	F 0514	<p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>Resident B no longer resides in this facility</p> <p>Resident C was assessed by a licensed nurse, with no adverse effects noted. No pain or discomfort voiced. MD and family notified. No new orders.</p> <p>Resident C's skin was re-assessed by the wound nurse and wound management was updated accordingly to reflect current skin condition</p> <p>Resident D's skin was re-assessed by the wound nurse. Measurements and descriptions for surgical wounds are documented under Non-Ulcer Events weekly. Non Ulcer Events were updated accordingly to reflect current skin condition.</p> <p>Resident D and resident C's treatment orders were reviewed for accuracy and updated as indicated for resident's current skin condition</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective</p>	09/22/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155230	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 08/29/2017
NAME OF PROVIDER OR SUPPLIER ROSEBUD VILLAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 2050 CHESTER BLVD RICHMOND, IN 47374		
(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
	<p>The narcotic log for the 12 mcg Fentanyl patch indicated it was administered on 7/28/17 and 7/31/17.</p> <p>A lined piece of notebook paper, noted with Resident B's name and date of birth, dated 7/28/17, indicated the following, "...new order 7/28/17...Fentanyl 25 mcg/hr [micrograms an hour] patch one patch [sic] change Q [every] 72 hours...." The patch was signed off as being administered on 7/28/17 and 8/3/17 but not for 7/31/17.</p> <p>It appears that Resident B received both Fentanyl 12 mcg and 25 mcg patch on 7/28/17. Resident B also received Fentanyl 12 mcg patch on 7/31/17 after it was changed to 25 mcg on 7/25/17.</p> <p>On 8/29/17 at 5:25 p.m., an interview was conducted with the Director of Nursing Services (DNS). She indicated the Fentanyl 12 mcg patch was not marked off as discontinued on the Medication Administration Record (MAR) for Resident B. That resulted in a medication error of the 12 mcg and the 25 mcg patch being signed off as given. Her expectations are for the nursing staff to cross out and mark discontinued and place the new order on the MAR.</p>		<p>actions will be taken?</p> <p>All residents with impaired skin integrity have the potential to be affected by this alleged deficient practice. An audit will be completed by 9/22/17 by DNS/designee for all residents with impaired skin integrity. Any other resident found to be effected will have an updated skin assessment documented, wound management updated when appropriate, weekly measurements documented, and will be observed for adverse effects.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</p> <p>Wound nurse will be re-educated on the Skin Management Program by Corporate Nurse by 9/22/17. Wound documentation will be reviewed weekly by IDT to ensure accuracy. Therapy will attend weekly wound rounds moving forward to provide additional oversight for residents with wounds</p> <p>Nurses will be re-educated on passing medications as ordered and accurately documenting in MARs TARs, and narcotic logs by 9/22/17 by DNS or designee. Nurses will be re-educated on removing all discontinued</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155230	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 08/29/2017
NAME OF PROVIDER OR SUPPLIER ROSEBUD VILLAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 2050 CHESTER BLVD RICHMOND, IN 47374		
(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
	<p>1b. The following physician orders were noted for Resident B:</p> <p>"Morphine sulf [sulfate] 100 mg [milligrams]/5 mL [milliliters]...give 0.5 mL three times a day...." Order dated for 6/21/17.</p> <p>"Lorazepam 2 mg/mL...give 0.25 mL every 2 hours as needed...." Order dated for 4/25/17.</p> <p>"Lorazepam 2mg/mL...give 0.5 mL every 2 hours as needed...." Order dated for 4/25/17.</p> <p>The narcotic log for Morphine sulfate noted the following,</p> <ul style="list-style-type: none"> - 7/18/17 at 4:00 p.m., 0.5 mL given, 26 mL remains in bottle, - 7/18/17 at 8:00 p.m., 0.5 mL given, 25.5 mL remains, and - 7/19/17 at 8:00 a.m., 0.5 mL given, 24.0 mL remains. <p>The narcotic log for Lorazepam noted the following,</p> <ul style="list-style-type: none"> - 7/11/17 at 5:00 p.m., 0.5 mL given, 12.50 mL remains in bottle, & - 7/22/17 at 5:00 p.m., 0.5 mL given, 12.25 mL remains in bottle. 		<p>medications from nurse's carts timely by 9/22/17 by DNS/designee. IDT will review Narcotic Logs daily to ensure Narcotics have been administered as ordered and signed out appropriately. MARs and TARs will be reviewed no less than weekly by DNS/designee to ensure documentation is accurate.</p> <p>How will the corrective actions be maintained to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <p>To ensure compliance, the DNS/designee is responsible for the completion of the Documentation QAPI tool weekly x 4 weeks, monthly x 6 months, and then quarterly until continued compliance is maintained for two consecutive quarters. The results of these audits will be reviewed during monthly QAPI meeting, overseen by the ED. If the threshold of 95% is not achieved an action plan will be developed to ensure compliance and disciplinary action taken as needed.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155230	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 08/29/2017
NAME OF PROVIDER OR SUPPLIER ROSEBUD VILLAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 2050 CHESTER BLVD RICHMOND, IN 47374		
(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
	<p>An interview was conducted with the DNS on 8/29/17 at 10:46 a.m. She indicated the calculations on the narcotic log are not correct. Her expectations are for the liquid medications to be calculated per what is administered.</p> <p>A policy titled "Medication Pass Procedure", review date of 12/2016, was provided by the DNS on 8/29/17 at 10:44 a.m. The policy indicated the following, "...Procedure steps:...6. Perform the 5 rights of medication...Right Resident...Right Medication...Right dose...Right route...Right time...."</p> <p>2a. The clinical record for Resident C was reviewed on 8/28/17 at 11:07 a.m. The diagnoses included, but were not limited to, Alzheimer's dementia, scrotal discomfort, and venous stasis ulcer of right lower extremity.</p> <p>Resident C had the following physician order, "...Tylenol #3 with codeine every 4 hours...Dx: [diagnosis] pain...." The order was dated 8/25/17. Prior to that, Resident C had an order for Tylenol #3 with codeine, one tablet four times a day that was dated for 8/17/17.</p> <p>The controlled substance record for Resident C noted the following date/time(s) the Tylenol #3 with codeine</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155230	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 08/29/2017
NAME OF PROVIDER OR SUPPLIER ROSEBUD VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 2050 CHESTER BLVD RICHMOND, IN 47374	
(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)
	<p>was administered:</p> <p>8/22/17 at 6:00 a.m., 8/22/17 at 6:00 p.m., 8/25/17 at 6:00 p.m., 8/26/17 at 2:00 a.m., 8/26/17 at 10:00 a.m., & 8/26/17 at 2:00 p.m.</p> <p>The MAR for Resident C noted the dose on 8/22/17 at 12:00 p.m. was left blank, indicating it wasn't given. The MAR shows the last dose of the Tylenol #3 with codeine to administer four times a day was last given on 8/25/17 at 6:00 p.m.</p> <p>The MAR indicated the Tylenol #3 with codeine, give every 4 hours scheduled, was left blank for 8/25/17 at 10:00 p.m. and 8/26/17 at 6:00 a.m.</p> <p>On 8/29/17 at 8:40 a.m., an interview was conducted with the DNS. She indicated she was unable to find a reason as to why Resident C didn't receive the Tylenol #3 with codeine on 8/22/17 at 12:00 p.m., 8/25/17 at 10:00 p.m., and 8/26/17 at 6:00 a.m.</p> <p>2b. The clinical record indicated Resident C had a venous ulcer to his left shin that was identified on 6/9/17. Resident C also had a venous ulcer to the top of his left</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155230	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 08/29/2017
NAME OF PROVIDER OR SUPPLIER ROSEBUD VILLAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 2050 CHESTER BLVD RICHMOND, IN 47374		
(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
	<p>foot that was identified on 8/3/17.</p> <p>A document titled "Wound Management" was provided by the DNS on 8/28/17 at 3:08 p.m. The document indicated the following date(s) of wound assessments for the left shin:</p> <p>6/9/17, 7/21/17, 7/29/17, 8/7/17, & 8/23/17.</p> <p>The "Wound Management" document indicated the following date(s) of wound assessments completed for the top of the left foot:</p> <p>8/3/17, & 8/23/17.</p> <p>A form titled "Bedside Wound Team Minutes" was provided by the DNS on 8/28/17 at 12:30 p.m. The form indicated the following date(s) and information present on the forms:</p> <p>7/7/17 with measurements completed, 7/14/17 with measurements completed, 7/21/17 with measurements completed, 7/29/17 with measurements completed, 8/7/17 with no measurements noted, & 8/17/17 with measurements completed.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155230	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 08/29/2017	
NAME OF PROVIDER OR SUPPLIER ROSEBUD VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 2050 CHESTER BLVD RICHMOND, IN 47374		
(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
	<p>On 8/29/17 at 12:15 p.m., the DNS indicated if there is a pressure and/or venous ulcer, the assessment should be documented under wound management. She indicated the wounds should be assessed weekly and inputted into the clinical record for each resident. The skin minutes sheet is not part of the clinical record but a tool that the facility uses to make notes of the wound assessments.</p> <p>3a. The clinical record for Resident D was reviewed on 8/28/17 at 11:00 a.m. The diagnoses included, but were not limited to, right above the knee amputation, pain, and ischemic gangrene to right leg. A Significant Change Minimum Data Set, dated 8/22/17, noted a Brief Interview for Mental Status score of 13 indicating Resident D was cognitively intact.</p> <p>An interview was conducted with Resident D on 8/28/17 at 11:55 a.m. He indicated he has a surgical wound to his right groin area and the left side of his abdomen from where he used to have a colostomy. He indicated his dressings are not changed on a regular basis. The dressings are changed weekly and he believes it is supposed to be more often than that. He had an area to his right thigh area that was due to his "shrink</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155230	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	(X3) DATE SURVEY COMPLETED 08/29/2017
NAME OF PROVIDER OR SUPPLIER ROSEBUD VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 2050 CHESTER BLVD RICHMOND, IN 47374	
(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)
	<p>wrap" that he wore to be fitted for a prosthesis. The area to his right thigh is believed to be healed per Resident D.</p> <p>The following skin concerns were noted in Resident D's clinical record:</p> <p>Surgical wound to left abdomen that was noted on 4/12/17,</p> <p>Surgical wound to right groin that was noted on 1/9/17,</p> <p>Surgical wound to right stump that was noted on 5/30/17, &</p> <p>Pressure ulcer to right inner thigh that was noted on 7/31/17.</p> <p>The "Wound Management" section of Resident D's clinical record didn't have any assessments of his wounds noted.</p> <p>The following "Observations" were noted in Resident D's chart with the following information:</p> <p>7/4/17- list of wounds with no measurements,</p> <p>7/17/17- list of wounds with no measurements,</p> <p>8/5/17- list of wounds with no measurements,</p> <p>8/15/17 - list of wounds with no measurements,</p> <p>8/25/17- list of wounds with no measurements.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155230	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 08/29/2017
NAME OF PROVIDER OR SUPPLIER ROSEBUD VILLAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 2050 CHESTER BLVD RICHMOND, IN 47374		
(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
	<p>The following "events" were documented in Resident D's clinical record on the following date(s):</p> <p>7/3/17 - right stump with measurements obtained,</p> <p>7/4/17 - left abdomen and groin with measurements obtained,</p> <p>7/17/17 - left abdomen and groin with measurements and right stump without measurements,</p> <p>7/20/17 - groin with measurements,</p> <p>7/21/17 - left abdomen with measurements,</p> <p>7/31/17 - pressure to right inner thigh with measurements,</p> <p>8/8/17- left abdomen and right stump with measurements,</p> <p>8/14/17 - coccyx with no measurements,</p> <p>8/15/17 - left heel "boggy" with no measurements, &</p> <p>8/18/17 - groin and left abdomen with measurements.</p> <p>A form titled "Bedside Wound Team Minutes" was provided by the DNS on 8/28/17 at 12:30 p.m. The form indicated the following assessment date(s) for Resident D's wounds:</p> <p>7/4/17 - no measurements noted,</p> <p>7/10/17 - no measurements,</p> <p>7/17/17 - no measurements,</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155230	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 08/29/2017	
NAME OF PROVIDER OR SUPPLIER ROSEBUD VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 2050 CHESTER BLVD RICHMOND, IN 47374		
(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
	<p>7/24/17 - measurements obtained, & 8/15/17 - measurements taken of pressure ulcer to thigh area. No other measurements noted.</p> <p>On 8/29/17 at 10:46 a.m., the DNS indicated when the area to Resident D's right thigh area was noted on 7/31/17 it was cleared up a few days after that. The order for the treatment should have been discontinued. If an area has healed it should be documented in the clinical record and then discontinue the treatment.</p> <p>A progress note, dated 8/5/17, indicated Resident D had a stage 2 blister to his right inner thigh. New order to discontinue current treatment and start skin prep and leave open to air.</p> <p>There was no order for skin prep on the physician order sheet and/or the MAR.</p> <p>On 8/29/17 at 12:15 p.m., the DNS indicated if there is a pressure and/or venous ulcer, the assessment should be documented under wound management. If it's a non pressure wound, it's then documented under a skin "event" in the electronic medical record. She indicated the wounds should be assessed weekly and inputted into the clinical record for each resident. The skin minutes sheet is</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155230	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	(X3) DATE SURVEY COMPLETED 08/29/2017
NAME OF PROVIDER OR SUPPLIER ROSEBUD VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 2050 CHESTER BLVD RICHMOND, IN 47374	
(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
	<p>not part of the clinical record but a tool that the facility uses to make notes of the wound assessments.</p> <p>3b. The following physician order was noted for Resident D, "...clean thigh pressure ulcer with normal saline and apply Bactroban ointment BID [twice daily]...." The order was dated for 7/31/17.</p> <p>The August, 2017 MAR noted the above order for twice a day but all of the boxes are blank. There was no indication that the order was discontinued. There was no order for such in the July, 2017 MAR and/or TAR.</p> <p>On 8/29/17 at 10:46 a.m., the DNS indicated when the area to Resident D's right thigh area was noted on 7/31/17 it was cleared up a few days after that. The order for the treatment should have been discontinued. If an area has healed it should be documented in the clinical record and then discontinue the treatment.</p> <p>A policy titled "Skin Management Program", dated 3/10, was provided by the DNS on 8/28/17 at 3:08 p.m. The policy indicated the following, "...Weekly skin assessments will be completed on all residents with or without alterations in</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155230	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 08/29/2017	
NAME OF PROVIDER OR SUPPLIER ROSEBUD VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 2050 CHESTER BLVD RICHMOND, IN 47374		
(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
	<p>skin integrity and documented on the weekly skin assessment form...The facility assigned wound nurse will complete a further evaluation of the wounds identified...6. The IDT team will do rounds on a weekly basis to assess all wounds following the guidelines in the wound meeting guidelines...The wound nurse is responsible for updating the wound composite reports on a weekly basis and reporting the results to the DNS...."</p> <p>This federal tag relates to Complaints IN00236074 and IN00237771.</p> <p>3.1-50(a)(1) 3.1-50(a)(2) 3.1-50(a)(3)</p>				

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

PRINTED: 09/22/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155230	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 08/29/2017	
NAME OF PROVIDER OR SUPPLIER ROSEBUD VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 2050 CHESTER BLVD RICHMOND, IN 47374		
(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