

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155474	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/20/2012
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NAME OF PROVIDER OR SUPPLIER KINDRED NURSING AND REHABILITATION-BREMEN	STREET ADDRESS, CITY, STATE, ZIP CODE 316 WOODIES LN BREMEN, IN 46506
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F0000	<p>This visit was for the Investigation of Complaints IN00110505, IN00110790, and IN00111605.</p> <p>Complaint IN00110505-Substantiated. Federal/state deficiencies related to the allegations are cited at F224 and F312.</p> <p>Complaint IN00110790-Substantiated. Federal/state deficiencies related to the allegations are cited at F157, F224, F282, F309, F312, F315, and F502.</p> <p>Complaint IN00111605-Substantiated. Federal/state deficiencies related to the allegation are cited at F223, F224, F312, and F323.</p> <p>Survey dates: July 17, 18, 19, & 20, 2012</p> <p>Facility number: 000506 Provider number: 155474 AIM number: 100266530</p> <p>Survey team: Janet Adams, RN, TC Shannon Pietraszewski, RN July 17, 18, & 20, 2012</p> <p>Census bed type: SNF/NF: 92 Total: 92</p>	F0000	The facility requests that this plan of correction be considered its credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.	

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.

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	<p>Census payor type: Medicare: 9 Medicaid: 61 Other: 22 Total: 92</p> <p>Sample: 12</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review 7/26/12 by Suzanne Williams, RN</p>				

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F0157 SS=E	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on observation, record review, and interview, the facility failed to ensure the resident's physician was notified of lacerations, pain, and weight loss, for 4 of 12 residents reviewed for physician</p>	F0157	It is the practice of this facility to ensure the highest quality of care is afforded our residents. Consistent with this practice, the following has been done: <i>The corrective action taken for the</i>	08/19/2012			

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	<p>notification in the sample of 12. (Residents #C, #F, #G, and #K)</p> <p>Findings include:</p> <p>1. On 7/19/12 at 1:25 p.m., Resident #G was observed sitting in a wheelchair in her room. LPN #1 was present in the resident's room. The resident had a scabbed laceration to the left shin area. The area was approximately 1.5 cm (centimeters) in length. There was no dressing on the area at this time.</p> <p>The record for Resident #G was reviewed on 7/18/12 at 1:00 p.m. The resident's diagnoses included, but were not limited to, depression, dementia, joint replacement, high blood pressure, osteoporosis, and anxiety state.</p> <p>Review of the 7/2012 Physician orders indicated there was an order to apply Steri Strips (thin bandage strips used to help keep lacerations or an open area together), to approximate edges of wound, cover the area with calcium alginate (a type of bandage) and wrap with Kerlix daily. The Physician's order was written on 7/16/12.</p> <p>The 7/2012 Resident Progress Notes were reviewed. A Nursing entry made on 7/15/12 at 9:00 p.m., indicated the resident was adjusting herself in the</p>		<p><i>residents found to have been affected by the deficient practice was:</i> Resident's F, G, and K were reassessed. Physician and family were informed related to their condition. Resident C no longer resides at the facility. Therefore, no further corrective action could be taken for this resident. <i>The corrective action taken for those residents having the potential to be affected by the same deficient practice is:</i> All residents have the potential to be affected, therefore, this plan of correction applies to all residents. The 24 hour report book has been reviewed five times weekly for the last 30 days. This intervention will continue at least five times weekly ongoing. All residents with non pressure skin areas have the potential to be affected. All residents with weight loss have the potential to be affected. All residents with pain have the potential to be affected. A review of all residents with non-pressure areas, weight loss and on going pain has been reviewed for MD notification and any findings have been addressed with the MD. All residents with non-pressure skin areas have current MD orders for treatment. All residents with weight loss have been reviewed by the RD and the MD contacted for any recommendations to be implemented. All residents with unrelieved pain have had a pain assessment completed and MD</p>				

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	<p>wheel chair and a Kleenex box was knocked off the table and caused a 1.2 cm laceration to the left lower leg. A Nursing entry made on 7/16/12 at 10:00 p.m. indicated a new order was received from the Physician to apply Steri Strips.</p> <p>A Weekly Non Pressure Skin Condition Report was initiated on 7/15/12. The report indicated a laceration was first observed to the left lower extremity on 7/15/12. The report indicated the laceration measured 1.2 cm on 7/15/12.</p> <p>A Fax Cover Letter dated 7/16/12, indicated a fax was sent to the Physician at 2:44 p.m. The fax indicated the resident had a skin tear to the left shin and staff requested an order to apply Steri Strips to the approximated edges for wound closure.</p> <p>When interviewed on 7/19/12 at 2:40 p.m., the DON (Director of Nursing) indicated the Physician should have been called at the time the laceration occurred.</p> <p>2. The record for Resident #F was reviewed on 7/17/12 at 2:00 p.m. The resident's diagnoses included, but were not limited to, heart failure, high blood pressure, coronary artery disease, and atrial fibrillation (an irregular heart beat).</p>		<p>contacted for interventions related to relieving pain. <i>The measures put into place and a systemic change made to ensure the deficient practice does not recur is:</i> Nursing center licensed staff has been educated relative to notification of changes, including but not limited to, physician and family notification, including weight loss, pain, and lacerations/skin tears. <i>To ensure the deficient practice does not recur, the monitoring system established is:</i> A Performance Improvement indicator has been established which evaluates compliance with physician and family notification. The Director of Nursing or designee will complete the indicator weekly for the first month, monthly for the first quarter and quarterly thereafter. Any identified concerns will be promptly addressed with responsible individual(s). The DNS/Designee will review 5 times weekly in IDT meeting the 24 hour report sheets for change in condition and MD notification as an on going practice in the AM IDT meeting. All findings will be addressed with Nursing and education provided. All findings will be monitored in monthly PI meeting on going as part of the facilities PI process. DNS, or designee, will review results during the monthly performance improvement committee meeting to determine the need for continued monitoring</p>		

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	<p>The 6/2012 Physician orders were reviewed. An order written on 6/21/12 indicated Bacitracin (an antibiotic ointment) was to be applied to the right upper extremity and then the area was to covered with telfa (a non stick bandage) and wrapped with Kerlix (a dressing used to wrap around wounds) after cleansing the area daily.</p> <p>The 6/2012 Resident Progress Notes were reviewed. An entry was made by Nursing on 6/19/12 at 4:00 p.m. The entry indicated a skin tear measuring 6.3 cm x 4.8 cm was noted to the resident's right upper arm and the area was cleansed with normal saline, and the staff could not approximate the skin flap. The entry indicated the Physician was notified. The entry did not indicate if the Physician was called on the phone or faxed at this time. An entry completed by Nursing on 6/21/12 at 2:00 p.m. indicated a new Physician order was obtained for a treatment to the right upper arm.</p> <p>A Fax Cover Letter dated 6/19/12 at 4:30 p.m. indicated a skin tear was noted to the right upper extremity measuring 6.3 cm x 4.8 cm. The Fax Cover Letter also indicated staff requested an order to apply Bacitracin, telfa bandage secured with a Kerlix to be applied after cleaning the area with normal saline.</p>		or resolution.				

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	<p>The facility policy titled "Condition Change of a Resident" was received from the DON on 7/19/12 at 2:00 p.m. The DON indicated the policy was current. The policy indicated the Physician is to be informed of resident events and/or change in resident's condition.</p> <p>When interviewed on 6/19/12 at 2:40 p.m., the DON indicated the Physician should have been called on 6/19/12 for a treatment order if staff did not receive a response from the fax notification.</p> <p>3. Resident C's closed chart was reviewed on 7/17/12 at 3:40 p.m. Resident C's diagnoses included but were not limited to dementia, weakness, and osteoarthritis.</p> <p>During this time, Resident C's Plan of Care dated 4/10/12 indicated the resident was at risk for weight loss. The interventions included "...monitor % (percentage) of food/fluids consumed...continue to monitor weights, labs, PO (by mouth) intake and other nutritional parameters with each nutritional review..."</p> <p>The ADL (Activities of Daily Living) flow sheet indicated the resident needs extensive assistance of one person for meals.</p>			

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	<p>Resident C's weight record for May 2012 indicated a weight loss of 6 pounds from 5/7/12 to 5/26/12. The resident's meal intake record during this time indicated she consumed zero to 50% of food 44 out of 60 meals. 20 out of 60 meals, the resident was offered and refused alternative meals. The documentation did not indicate the percentage of snacks consumed.</p> <p>An interview with the ADON (Assistant Director of Nursing) on 7/20/12 at 1:30 p.m., indicated she was not able to find documentation of the physician being notified of the weight loss.</p> <p>4. Resident K's record was reviewed on 7/18/12 at 3:43 p.m. Resident K's diagnoses included, but were not limited to, CVA (stroke), COPD (congested obstructive pulmonary disease), atrial fibrillation, and dementia.</p> <p>On 7/18/12 at 10:20 a.m., the resident was observed moaning in bed. At 12:00 p.m., LPN #1 was interviewed regarding the resident's pain. LPN #1 indicated a nurse from the hospital told her the resident moaning is "something she does" and no one has informed her of the resident's pain this morning. She also indicated the resident receives scheduled pain</p>						

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	<p>medication, and she gave her Tylenol between 8 a.m. and 9 a.m., so it was not time for the resident to have anymore pain medication.</p> <p>On 7/18/12 at 12:30 p.m., the resident was observed and continue to moan in discomfort. The resident indicated she was in pain and moved her hand toward her pelvic area. During this time, the DON was made aware, and she indicated she will make sure the resident receives pain medication right away.</p> <p>On 7/18/12 at 4:00 p.m., the Pain Monitoring Flowsheet at 9:00 a.m. indicated the resident's pain rating as a "7" which meant the resident had moderate to severe pain. Resident K received Tylenol at that time for pain in the peri area. The post pain rating at an unknown time indicated a "2" which meant the resident continued to be in slight pain. At 1:30 p.m., the resident received Tylenol for "c/o (complaints of) headache" at a level of "6" which meant moderate pain. No post pain rating was written.</p> <p>The 7/17/12 Pain Interdisciplinary Care Plan for Resident K indicated the resident had severe, acute pain often AEB (as evidenced by) crying/moaning and facial grimace. The goal indicated "Resident</p>						

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	<p>will state/demonstrate relief or reduction in pain intensity within 30 minutes after receiving interventions". The interventions indicated to "...report changes in pain location/type frequency/intensity to physician...Notify the resident's physician if they do not state/demonstrate relief or reduction of pain after one hour of receiving the first intervention..."</p> <p>A nursing note on 7/18/12 at 3 p.m. did not indicate the physician was informed of the resident's pain not being relieved. The Medical Director progress note for 7/18/12 indicated "initial physician eval (evaluation) done."</p> <p>This federal tag relates to Complaint IN00110790.</p> <p>3.1-5(a)(2) 3.1-5(a)(3)</p>				

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F0223 SS=A	<p>483.13(b), 483.13(b)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION</p> <p>The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.</p> <p>The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion.</p> <p>Based on record review and interview, the facility failed to ensure residents remained free of verbal and physical abuse for 2 of 2 allegations of abuse reviewed. (Residents #B, #J, #N) (CNA #7 and Unit Director#1)</p> <p>Finding include:</p> <p>1. A facility reported allegation of verbal abuse to Resident #B was reviewed on 7/20/12 at 1:15 p.m. The report indicated CNA #D reported an allegation of verbal abuse on 7/17/2012. The report indicated CNA #D reported she heard CNA #7 talking to Resident #B, and CNA #7 stated to Resident #B "what are you doing, get out of that bed, it isn't made." CNA #D then went into the room and the resident told her she had a "mess" in her pants and CNA #7 then yelled at the resident saying "if you had a mess in your pants why did you lay down in the first place, I told you to get out of that bed,</p>	F0223	<p>It is the practice of this facility to ensure the highest quality of care is afforded our residents. Consistent with this practice, the following has been done: <i>The corrective action taken for the residents found to have been affected by the deficient practice was: C.N.A. #7 and Unit Director #1 was suspended at the time of the allegation was made. An investigation was conducted. Based on the investigation findings, the C.N.A. and the Unit Director were terminated from the facility. The allegations were brought to the attention of the ISDH surveyors during the time of the survey. They also investigated the two allegations of abuse. The corrective action taken for those residents having the potential to be affected by the same deficient practice is: All residents have the potential to be affected, thus, this plan of correction applies to all residents. The facility did interviews with all residents and/or families. The measures put into place and a systemic</i></p>	08/19/2012	

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	<p>look at your blanket, look what you did, you couldn't have waited 5 seconds for me. Now I have more work to do. Thank you very much."</p> <p>CNA #B also reported she dressed Resident #J that day and she did not want to get up in the wheelchair but she needed to be pulled up in her bed. CNA #B went to locate CNA #7 for assistance and CNA#7 told the resident if she wanted to be up for lunch she was getting up now and she put the resident's shoes on after the resident said she did not want them on. The CNA then brought the hooyer lift into the room and "whipped" it around and it almost hit the resident.</p> <p>When interviewed on 7/20/12 at 1:20 p.m. the DON indicated the CNA was suspended at the time. The DON indicated an investigation was initiated including interviewing residents and staff. The DON indicated the allegations of Abuse were substantiated. Social Service followed up with the residents without any further concerns. CNA #7 has not returned to work.</p> <p>2. A second facility reported allegation of abuse was also reviewed on 7/20/12 at 1:15 p.m. The report indicated on 7/19/12 at 10:30 a.m., Unit Director #1 was observed trying to remove Resident</p>		<p><i>change made to ensure the deficient practice does not recur is: Nursing center staff was educated relative to abuse, prevention of abuse, investigation, and reporting. To ensure the deficient practice does not recur, the monitoring system established is: A Performance Improvement indicator has been established which evaluates compliance with the abuse policy. The Executive Director, Director of Nursing or designee will complete indicator weekly for the first month, monthly for the first quarter and quarterly thereafter. Any identified concerns will be promptly addressed with responsible individual(s). All findings discovered thru resident interviews, observations and family interviews have a Concern/ Grievance completed and IDT review for follow thru. Resident Interviews, observations and family interviews will be an on going process completed Quarterly for 50 residents as a PI process and reviewed monthly in PI for compliance. This will be part of the PI meeting and monitored for 100% compliance. ED, DNS, or designee, will review results during the monthly performance improvement committee meeting to determine the need for continued monitoring or resolution.</i></p>		

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	<p>#N, who was displaying combative behavior, from the Dining Room. The report indicated Employee #1 observed the Unit Director pulling Resident #N and pushing him down in the chair. The Unit Director was suspended at the time and not returned to work. Staff interviews were also obtained. Inservice education on Abuse and Neglect and appropriate interventions for behavioral issues were started for the staff. Resident #N was assigned a staff nurse to do one on one with the resident.</p> <p>When interviewed on 7/20/2012 at 1:20 p.m., the DON indicated the staff member was suspended and has not returned to the facility.</p> <p>This federal tag relates to Complaint IN00111605.</p> <p>3.1-28(a)</p>				

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(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	
F0224 SS=D	<p>483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRI ATN</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>Based on observation, record review, and interview, the facility failed to ensure residents were free of neglect related to call lights not answered in a timely manner for 3 of 12 residents observed for answering call lights in a timely manner in the sample of 12. (Residents #M, #K, and #J)</p> <p>Findings include:</p> <p>1. On 7/18/12 at 6:34 p.m., a call light was observed on outside of Resident #M's room. There were no staff members in the room at this time. At 6:36 a.m. a CNA was observed walking down the same hall as Resident #M. The CNA entered another room without answering the above call light that was still on. The CNA came out of the other resident's room with a resident in a wheel chair and took that resident to the "Toilet Room." The CNA did not address Resident #M's call light which was still on. At this time, RN #2 was entering a room next to the "Storage Room" on Resident M's hall.</p>	F0224	<p>It is the practice of this facility to ensure the highest quality of care is afforded our residents. Consistent with this practice, the following has been done: <i>The corrective action taken for the residents found to have been affected by the deficient practice was:</i> Resident's M, K, and J received appropriate care at the time of discovery during the survey. <i>The corrective action taken for those residents having the potential to be affected by the same deficient practice is:</i> All residents have the potential to be affected. All residents or families (for the residents unable to complete a resident interview) have been interviewed and resident observations have been completed for all residents residing in the facility in an effort to identify any concerns and all findings have been followed thru by administration with adherence to policies and procedures for abuse and neglect. <i>The measures put into place and a systemic change made to ensure the deficient practice does not recur is:</i> Nursing staff has been educated relative to</p>	08/19/2012	

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	<p>The RN did not address the call light that was still on.</p> <p>On 7/18/12 at 6:41 a.m. a CNA was observed coming out of another room on Resident #M's hall. The CNA did not address the call light that was still on. At 6:43 a.m., another CNA walked down the hall from the Nurses' Station. The CNA did not address the call light which was still on. At 6:46 a.m., RN #2 pushed the Medication Cart in front of the Nurses' Station on this hall and then proceeded to then push the Medication Cart to a resident room on this hall. At 6:48 a.m., a CNA entered Resident #M's room and went to her bed area. The CNA indicated Resident #M had her call light on as she wanted to get up.</p> <p>The record for Resident #M was reviewed on 7/19/12 at 8:00 a.m. The resident's diagnoses included, but were not limited to, Parkinson's disease, osteoarthritis, degenerative joint disease, and high blood pressure. The 7/6/2012 Minimum Data Set (MDS) quarterly assessment indicated the resident required extensive assist of staff for bed mobility, transfers, toileting, and personal hygiene. The assessment also indicated the resident was occasionally incontinent of urine.</p> <p>The 7/2012 Physician Order Statement</p>		<p>mistreatment/neglect/misappropriation, including but not limited to, answering call lights in a timely manner and provision of necessary care. <i>To ensure the deficient practice does not recur, the monitoring system established is:</i> A Performance Improvement indicator has been established which evaluates compliance with answering call lights in a timely manner on all shifts. The Director of Nursing or designee will complete indicator weekly for the first month, monthly for the first quarter and quarterly thereafter. Any identified concerns will be promptly addressed with responsible individual(s). All findings discovered thru resident interviews, observations and family interviews have a Concern/Grievance completed and IDT review for follow thru. Resident Interviews, observations and family interviews will be an on going process completed Quarterly for 50 residents as a PI process and reviewed monthly in PI for compliance. This will be part of the PI meeting and monitored for 100% compliance. DNS, or designee, will review results during the monthly performance improvement committee meeting to determine the need for continued monitoring or resolution.</p>		

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	<p>indicated there were Physician orders for the resident to receive three medications at 6:00 a.m. daily. The medications were Omeprazole, Sinemet, and Norco.</p> <p>When interviewed on 7/19/12 at 11:40 a.m., Resident #M indicated she requires help from the staff getting out of bed and that sometimes "it takes awhile" for them to answer the lights. The resident indicated this especially occurs in the morning as they come in early and give her medications and after she takes her pills she needs to use the bathroom.</p> <p>2. Resident J's record was reviewed on 7/18/12 at 12:00 p.m. Resident J's diagnoses included, but were not limited to, type two diabetes, atrial fibrillation, congested heart failure, dysphagia, aphasia, and CVA (cerebral vascular accident/stroke).</p> <p>On 7/18/12 at 9:50 a.m., the resident's call light was observed on. At 9:55 a.m., a therapist was observed going to the door of the room and walked away. At 10:00 a.m., the call light continued to be on. Two nurses, another therapist and a CNA (certified nursing assistant) had walked by the room and did not address the call light. Upon entering the room during this time, the resident was observed to be behind a closed curtain farthest from the entrance door and was having difficulty</p>			

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	<p>swallowing her medication, indicated by pointing to her medication cup and her throat. The resident nodded her head yes and spoke "No can" when asked if she is having difficulty swallowing her medication. RN#1 was called to the resident's room and the resident agreed to have the rest of her medications placed in applesauce.</p> <p>When interviewed on 7/18/12 at 10:05 a.m. , RN#1 indicated she had been taught it was acceptable to leave pills with the resident if the resident was known to take medications on their own. The RN indicated she leaves medications for Resident #J to take on her own.</p> <p>3. Resident K's record was reviewed on 7/18/12 at 3:43 p.m. Resident K's diagnoses included but were not limited to CVA, COPD (congested obstructive pulmonary disease), atrial fibrillation, and dementia.</p> <p>On 7/18/12 at 10:20 a.m., Resident #K was observed moaning in bed. SS #1 was in the room speaking with a family member of the room mate. SS #1 indicated she was going to get the nurse because the resident had been moaning. The resident indicated pain by nodding her head yes and rubbing the left lower quadrant of her stomach. SS #1 was</p>						

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	<p>observed turning on the call light and informed the resident she needed to use the call light if she needs assistance. At 10:23 a.m., LPN #1 was observed walking by the resident's room two times. At 10:25 a.m., CNA #3 walked into the resident's room and then was observed going to the location of LPN #1. LPN #1 did not address the resident's pain as she went into another resident's room to do a dressing change. CNA # 1 and ADON went to the resident's room at 10:35 a.m. RN #1 was observed asking CNA #1 if the resident indicated what was wrong and proceeded to walk down her responsible corridor. The Admissions Coordinator was observed entering Resident K's room at 10:45 a.m. and then to the location of LPN #1. RN #1 was observed getting a resident from the activity room and walked down her responsible hallway.</p> <p>The resident's call light was observed turned off at 10:55 a.m. as the Admissions Coordinator and SS #1 walked out of the resident's room. No staff members were observed going into the resident's room between 10:55 a.m. and 11:27 a.m. The resident continued to moan. From 11:27 a.m. to 11:35 a.m., LPN #1 was observed coming out of a resident's room multiple times to go to the medication cart before going to the lunch</p>			

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	<p>room.</p> <p>CNA #1 and CNA #3 returned to Resident K's room to assist her room mate at 11:40 a.m. At 11:45 a.m., LPN #1 was observed bringing Resident K's lunch and asked her how her pain was. The resident was observed to still be moaning. LPN #1 was observed pulling the resident's curtains, walked out of the room and walked back to the dining room where she was observed passing out trays.</p> <p>At 12:30 p.m., Resident #K continued to moan in discomfort. The resident indicated she was in pain by moving her hand toward her pelvic area when asked where her pain was. During this time, the DON was made aware and she indicated she will make sure the resident receives pain medication right away.</p> <p>On 7/18/12 at 4:00 p.m., the Pain Monitoring Flowsheet at 9:00 a.m. indicated the resident's pain rating as a "7" which meant the resident had moderate to severe pain. Resident K received Tylenol at that time for pain in the peri area. The post pain rating at an unknown time indicated a "2" which meant the resident continued to be in slight pain. At 1:30 p.m., the resident received Tylenol for "c/o (complaints of headache)" at a level of "6" which meant</p>				

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	<p>moderate pain. No post pain rating was written.</p> <p>4. A confidential interview with a family member on 7/18/12 at 12:20 p.m., indicated "I should not have to go find what my (title identifying how the family and the resident are related) needs for meals" and "I am always trying to find someone during the meals so my (title identifying how the family member and the resident are related) can go to the bathroom." The family member indicated he/she comes to the facility to see the family member daily for lunch and dinner and indicated "the weekends are worse". The family member indicated he/she verbalized the concerns or has attended the family counsel meetings in the past "but it did not do any good. Nothing got done."</p> <p>This federal tag relates to Complaints IN00110505, IN00110790, and IN00111605.</p> <p>3.1-27(a)(3)</p>						

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F0282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on record review and interview, the facility failed to follow the resident's plan of care related to monitoring and recording food and fluid intake for 3 of 3 residents identified with nutritional or weight loss concerns in the sample of 12. (Residents #C, #F, and #J)</p> <p>Finding include:</p> <p>1. The record for Resident #F was reviewed on 6/17/12 at 2:00 p.m. The resident's diagnoses included, but were not limited to, heart failure, high blood pressure, coronary artery disease, and atrial fibrillation (an irregular heart beat).</p> <p>A care plan initiated on 4/1/12 indicated the resident was at risk for nutritional declines related to variable intakes of food/beverages, decreased self-feeding, and a restrictive or mechanically altered diet. The care plan was updated on 7/12/12 indicating the resident had a significant weight loss in the past month with a decrease in intakes. Care plan interventions included for staff to monitor/evaluate energy intake and/or</p>	F0282	<p>It is the practice of this facility to ensure the highest quality of care is afforded our residents. Consistent with this practice, the following has been done: <i>The corrective action taken for the residents found to have been affected by the deficient practice was:</i> Resident's F and J received appropriate care at the time of discovery during the survey. Resident C no longer resides at the facility. Therefore, no further corrective action could be taken for this resident. <i>The corrective action taken for those residents having the potential to be affected by the same deficient practice is:</i></p> <p>All residents have the potential to be affected. All residents with weight loss in the last 60 days have been reviewed for RD assessment and interventions, MD notification, and plan of care updated. All nursing staff have been in-serviced on Meal intake record and meal service as well as Licensed Nurses are recording the intake of meals on the meal intake record.</p> <p><i>The measures put into place and a systemic change made to ensure the deficient practice does not recur is:</i> Nursing staff has</p>	08/19/2012			

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	<p>food and beverage intake via meal intake records and observations.</p> <p>The July 2012 Individual Resident Meal Intake Record was reviewed. The record indicated the resident's breakfast meal intake was not recorded on 7/5/12, 7/10/12, 7/11/12, 7/14/12, and 7/17/12. The resident's lunch meal intake was not recorded on 7/14/12 and 7/15/12. The resident's dinner intake was not recorded on 7/1/12, 7/5/12, 7/6/12, 7/9/12, 7/10/12, 7/12/12- 7/15/2012. The resident's HS (night time) snack intake was not recorded 7/5/12, 7/7/12, 7/9/12, 7/10/12, and 7/12/12 - 7/15/2012.</p> <p>When interviewed on 7/18/12 at 1:50 p.m., the Registered Dietitian indicated the resident's meal intakes should have been recorded on the Meal Intake Record to be able to monitor the resident's food intake.</p> <p>2. Resident C's record was reviewed on 7/17/12 at 3:40 p.m. Resident C's</p>		<p>been educated relative to services by qualified persons/per care plan, including but not limited to, monitoring and recording food and fluid intake for the residents. <i>To ensure the deficient practice does not recur, the monitoring system established is:</i> A performance improvement indicator has been established that evaluates the compliance with recording food and fluid intake for all three meals. The Director of Nursing or designee will complete indicator weekly for the first month, monthly for the first quarter and quarterly thereafter. Any identified concerns will be promptly addressed with responsible individual(s). The DNS/ Designee will audit all meal intake record weekly for compliance for a month. Then monthly for a Quarter and then Quarterly. The DNS/UM will meet weekly wit the RD for review of residents with weight loss and review of meal intake records. This will be an on-going practice of this facility to monitor residents weekly with weight loss and reviewed in monthly PI for compliance. DNS, or designee, will review results during the monthly performance improvement committee meeting to determine the need for continued monitoring or resolution.</p>		

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	<p>diagnoses included but were not limited to dementia, weakness, and osteoarthritis.</p> <p>During this time, Resident C's Plan of Care dated 4/10/12 indicated a risk for weight loss. The interventions included "...monitor % (percentage) of food/fluids consumed...continue to monitor weights, labs, PO (by mouth) intake and other nutritional parameters with each nutritional review..."</p> <p>The ADL (Activities of Daily Living) flow sheet indicated the resident needed extensive assistance for meals.</p> <p>Resident C's weight record for May, 2012 indicated a weight loss of 6 pounds from 5/7/12 to 5/26/12. The resident's meal intake record during this time indicated 44 out of 60 meals, the resident consumed zero to 50%. 20 out of 60 meals, the resident was offered and refused alternative meals. Documentation did not indicate the resident's snack consumption.</p> <p>3. Resident J's record was reviewed on 7/18/12 at 12:00 p.m. The resident's diagnoses included, but were not limited to, type two diabetes, atrial fibrillation, congested heart failure, dysphagia, aphasia, and CVA (cerebral vascular accident/stroke).</p>			

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	<p>A care plan last dated 4/10/12, indicated the resident was at risk for weight loss. Care plan interventions included to monitor the percentage of foods and fluids consumed and to continue to monitor the resident's weights, labs, and oral intake and other nutritional parameters at each nutritional review.</p> <p>The "Meal Intake Record" for June 2012 indicated 34 out of 90 meals did not indicate how much food was eaten at the particular meal time. One breakfast and one lunch alternative was offered the entire month. 31 snack times did not indicate if resident was offered a snack. Fluid consumption was indicated in the other "snack" sections. The month of July, 2012 indicated 18 out of 57 meal did not indicate how much food was eaten at the particular meal time. No alternatives were offered/indicated when the resident consumed five to 40% of meals. Fluid consumption amounts was indicated in the "snack" sections.</p> <p>The MDS (Minimum Data Set) assessment on 7/6/12 indicated the resident needed supervision with oversight, encouragement or cueing for meals. The MDS also indicated the resident had upper and lower extremity limited ROM (range of motion) due to</p>			

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	<p>hemiplegia. The ADL Care Plan dated 2/7/12 did not indicate the resident's need for assistance for meals. No nutrition assessment/care plan was provided.</p> <p>Interview with the Administrator and DON (Director of Nursing) on 7/20/12 at 12:30 p.m., acknowledged the staff did not monitor and document the meal consumption sheet correctly. She indicated dietary supplements should not be indicated as snacks since they are given at meals or with medications.</p> <p>This federal tag relates to Complaint IN00110790.</p> <p>3.1-35(g)(2)</p>			

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F0309 SS=G	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on observation, record review, and interview, the facility failed to assess and provide care for a resident in pain in a timely manner for 1 of 11 residents reviewed for pain in the sample of 12, which resulted in the resident experiencing unrelieved pain. (Resident #K)</p> <p>The facility also failed to ensure treatment and services were provided for skin tears and lacerations for 1 of 3 residents reviewed for skin conditions in the sample of 12. (Resident #G)</p> <p>Findings include:</p> <p>1. Resident #K's record was reviewed on 7/18/12 at 3:43 p.m. Resident K's diagnoses included, but were not limited to, CVA (stroke), COPD (congestive obstructive pulmonary disease), atrial fibrillation, and dementia. The resident was admitted to the facility on 6/27/12.</p> <p>On 7/18/12 at 10:20 a.m., Resident #K</p>	F0309	<p>It is the practice of this facility to ensure the highest quality of care is afforded our residents. Consistent with this practice, the following has been done: <i>The corrective action taken for the residents found to have been affected by the deficient practice was:</i> Resident's K and G received appropriate care at the time of discovery during the survey. <i>The corrective action taken for those residents having the potential to be affected by the same deficient practice is:</i> All residents with pain and skin tears/lacerations have the potential to be affected, thus, this plan of correction applies to any resident with those conditions. All residents with on unrelieved pain have the potential to be affected. A review of all residents with scheduled or PRN pain meds has been reviewed for effectiveness of current pain management and if current plan of care is ineffective in managing pain the MD has been contacted and plan of care revised. All residents with an order for a treatment requiring a dressing application have the potential to</p>	08/19/2012			

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	was observed moaning in bed. SS #1 was in the room speaking with a family member of the room mate. SS #1 indicated she was going to get the nurse because the resident had been moaning. The resident indicated pain by nodding her head yes and rubbing the left lower quadrant of her stomach. SS #1 was observed turning on the call light and informed the resident she needed to use the call light if she needs assistance. At 10:23 a.m., LPN #1 was observed walking by the resident's room two times. At 10:25 a.m., CNA #3 walked into the resident's room and then was observed going to the location of LPN #1. LPN #1 did not address the resident's pain as she went into another resident's room to do a dressing change. CNA # 1 and ADON went to the resident's room at 10:35 a.m. RN #1 was observed asking CNA #1 if the resident indicated what was wrong and proceeded to walk down her responsible corridor. The Admissions Coordinator was observed entering Resident #K's room at 10:45 a.m. and then to the location of LPN #1. RN #1 was observed getting a resident from the activity room and walked down her responsible hallway. The resident's call light was observed turned off at 10:55 a.m. as the Admissions Coordinator and SS #1 walked out of the resident's room. No staff were observed going into the		be affected. All nursing staff have been in-serviced on policy and procedures for Clean Dressing Application and C.N.A.'s on notifying the nurse on dressings not in place during care. <i>The measures put into place and a systemic change made to ensure the deficient practice does not recur is:</i> Nursing staff has been educated relative to provide care/services for highest well being, including but not limited to, providing care for a resident related to pain and ensuring dressings/treatments are in place for skin tears. <i>To ensure the deficient practice does not recur, the monitoring system established is:</i> A Performance Improvement indicator has been established which evaluates compliance with pain and treatments are in place for skin tears/lacerations on all shifts. The Director of Nursing or designee will complete indicator weekly for the first month, monthly for the first quarter and quarterly thereafter. Any identified concerns will be promptly addressed with responsible individual(s). The DNS/ Designee are verifying dressing applications weekly via random audits for one month then monthly for a quarter then quarterly and reviewing any findings in monthly PI until 100 % compliance is achieved. The DNS/Designee will review the 24 Hour Report Sheets for residents				

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	<p>resident's room between 10:55 a.m. and 11:27 a.m. The resident continued to moan. From 11:27 a.m. to 11:35 a.m., LPN #1 came out of a resident's room multiple times to go to the medication cart before going to the lunch room. CNA #1 and #3 returned to Resident K's room to assist her room mate at 11:40 a.m. At 11:45 a.m., LPN #1 was observed bringing Resident #K's lunch and asked her how her pain was. The resident was observed to still be moaning. LPN #1 was observed pulling the resident's curtains, walked out of the room and walked back to the dining room where she was observed passing out trays.</p> <p>LPN #1 was interviewed at this time regarding the resident's pain. LPN #1 indicated a nurse from the hospital told her the resident moaning is "something she does" and no one has informed her of the resident's pain. She also indicated the resident receives scheduled pain medication, and she gave her Tylenol between 8 a.m. and 9 a.m., so it was not time for the resident to have anymore pain medication.</p> <p>At 12:30 p.m., Resident #K continued to moan in discomfort. The resident indicated she was in pain by moving her hand toward her pelvic area when asked where her pain was. During this time, the</p>		with pain for effective interventions five times weekly in AM IDT meeting. Resident Interviews, Family interviews, staff interviews and resident observations will be completed quarterly as an ongoing practice of this facility and findings related to Pain addressed in PI for compliance 100% compliance with pain management. DNS, or designee, will review results during the monthly performance improvement committee meeting to determine the need for continued monitoring or resolution.		

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	<p>DON was made aware and she indicated she will make sure the resident receives pain medication right away.</p> <p>The current Pain Monitoring Flowsheet for 7/18/12 was reviewed on 7/20/12. The flowsheet indicated on 7/18/12 at 9:00 a.m. the resident's pain rating as a "7" which meant the resident had moderate to severe pain. Resident K received Tylenol at that time for pain in the peri area. The post pain rating for the above dose of Tylenol indicated a "2" which meant the resident continued to be in slight pain. The time the above post pain rating was completed was not documented on the flowsheet. At 1:30 p.m., the resident received Tylenol for "c/o (complaints of) headache" at a level of "6" which meant moderate pain. No post pain rating was written.</p> <p>The 7/2012 Medication Administration Record (MAR) indicated there was a Physician's order for the resident to receive two tablets of Tylenol 325 milligrams by mouth every four hours as needed for pain or an elevated temperature. There were no Physician orders for any pain medications to be given routinely. The MAR indicated the resident received the ordered Tylenol on 7/18/12 at 3:40 a.m., 9:00 a.m., and 1:30 p.m.</p>						

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	<p>The Pain Interdisciplinary Care Plan for Resident #K indicated the resident had severe, acute pain often AEB (as evidenced by) crying/moaning and facial grimace. The goal indicated "Resident will state/demonstrate relief or reduction in pain intensity within 30 minutes after receiving interventions". The interventions indicated to "...report changes in pain location/type frequency/intensity to physician...Notify the resident's physician if they do not state/demonstrate relief or reduction of pain after one hour of receiving the first intervention..."</p> <p>2. On 7/19/12 at 1:25 p.m., Resident #G was observed sitting in a wheelchair in her room. LPN#1 entered the resident's room to render a treatment to a laceration on her left lower leg. The resident lifted her left pant leg and a scabbed laceration was observed to the front of her left shin area. There was no dressing or bandage over the area. At this time, the resident indicated the dressing had been off since her shower this morning.</p> <p>The record for Resident #G was reviewed on 7/18/12 at 1:00 p.m. The resident's diagnoses included, but were not limited to, depression, joint replacement, osteoporosis, and high blood pressure.</p>			

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	<p>A Physician order was written on 7/16/12 for staff to apply Steri Strips to wound to approximate the edges for wound closure, then cover with calcium alginate and wrap the area with Kerlix (a rolled bandage to wrap around wounds) every day for 7 days.</p> <p>The 7/12 Resident Progress Notes were reviewed. An entry made by Nursing on 7/15/12 at 9:00 p.m. indicated the resident was adjusting herself in the wheel chair and a Kleenex box was knocked off the table hitting her left lower extremity and causing a laceration measuring 1.2 centimeters.</p> <p>When interviewed on 7/19/12 at 1:27 p.m., LPN #1 indicated she was not aware the resident's dressing was not in place. The LPN indicated CNA #4 was assigned to care for the resident today. LPN #1 indicated the CNA had not informed her the resident's dressing was off and the resident should have had a dressing in place as ordered by the Physician.</p> <p>When interviewed on 7/19/12 at 1:30 p.m., CNA #4 indicated she had given the resident a shower around 7:15 a.m. this morning. The CNA indicated the bandage was falling down the resident's leg and the resident removed the bandage. CNA #4 indicated she did not tell the</p>						

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	<p>Nurse the bandage was off.</p> <p>When interviewed on 7/19/12 at 2:40 p.m., the Director of Nursing indicated the resident should have had a dressing in place as ordered by the Physician.</p> <p>This federal tag relates to Complaint IN00110790.</p> <p>3.1-37(a)</p>			
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F0312 SS=D	<p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS</p> <p>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.</p> <p>Based on observation, record review, and interview, the facility failed to provide incontinence care, repositioning, and feeding assistance to 2 of 10 residents who were dependent on staff assistance for Activities of Daily Living in the sample of 12. (Residents #F and #D)</p> <p>Findings include:</p> <p>1. On 7/18/12 at 6:30 a.m., Resident #F was observed asleep in bed. The resident was positioned on his back.</p> <p>On 7/18/12 at 6:50 a.m. 7:18 a.m., 7:32 a.m., and 7:53 a.m. the resident remained in bed on his back in bed the same position. There were no staff members in the room with the resident.</p> <p>On 7/18/12 at 8:02 a.m., CNA #1 entered the resident's room and gave the resident's room mate a breakfast tray. The CNA then took a breakfast tray for Resident #F into the room and placed the covered breakfast tray on top of the dresser at the bedside. The resident was awake and the</p>	F0312	<p>It is the practice of this facility to ensure the highest quality of care is afforded our residents. Consistent with this practice, the following has been done: <i>The corrective action taken for the residents found to have been affected by the deficient practice was:</i> Resident's F and D received appropriate care at the time of discovery during the survey. <i>The corrective action taken for those residents having the potential to be affected by the same deficient practice is:</i> All residents have the potential to be affected. All Nursing staff have been in-serviced on ADL care to include emphasis on AM Care, Incontinent Care, Feeding residents, and Positioning residents.</p> <p><i>The measures put into place and a systemic change made to ensure the deficient practice does not recur is:</i> Nursing staff has been educated relative to ADL care provision for the dependent resident, including but not limited to, ensuring incontinence care, repositioning, and assistance with feeding is provided to the residents. <i>To ensure the deficient practice does not recur, the monitoring system established</i></p>	08/19/2012			

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	<p>CNA told the resident she would be back in to help him eat. On 7/18/12 at 8:06 a.m., the resident remained awake in bed and positioned on his back. The resident's covered breakfast tray remained on top of the dresser. On 7/18/12 at 8:16 a.m., the resident remained in bed on his back and the breakfast meal tray remained covered on the dresser. On 7/18/12 at 8:26 a.m., the resident remained in bed in the same position and his meal tray remained on the dresser. On 7/18/12 at 8:37 a.m., CNA #1 entered the resident's room and told the resident she would be back in a few minutes to feed him breakfast. The resident remained on his back in the same position. The CNA did not provide any incontinence care to the resident at this time. On 7/18/12 at 8:45 a.m. CNA#1 started feeding the resident his breakfast. The CNA did not provide any incontinence care before she starting feeding the resident. The CNA did not put the resident's dentures in his mouth before she started feeding the resident. The CNA finished feeding the resident at 9:05 a.m. and left the resident's room.</p> <p>On 7/18/12 at 9:20 a.m. and 9:30 a.m., the resident remained in bed on his back. There were no staff members in the room. On 7/18/12 at 9:39 a.m., the call light came on outside of the resident's room. The Nurse Consultant was at the room</p>		<p>is: A Performance Improvement indicator has been established which evaluates compliance with incontinence care, repositioning, and assistance with feeding on all shifts. The Director of Nursing or designee will complete indicator weekly for the first month, monthly for the first quarter and quarterly thereafter. Any identified concerns will be promptly addressed with responsible individual(s). The DNS / Designee are completing daily nursing rounds to monitor resident care and address any findings with individual staff through education or PI. All findings will be reviewed in monthly PI meeting for 6 months or until PI committee determines 100% compliance has been achieved. DNS, or designee, will review results during the monthly performance improvement committee meeting to determine the need for continued monitoring or resolution.</p>	

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	<p>and came out in the hallway and went to get the resident some juice.</p> <p>On 7/18/12 at 9:55 a.m., CNA #6 entered the resident's room with the Nurse Consultant, and the Nurse Consultant started putting the resident's shoes on. CNA #6 then left the room to get the resident a gown. CNA #2 and CNA #3 then entered the room and started to turn the resident to his side to place a bed pan under him. The resident did not have a brief or pants on. The cloth incontinence pad was wet. CNA #2 then placed the resident on a bed pan. After removing the bed pan and providing incontinence care, CNA #2 took the resident's dentures out of the denture cup in his drawer, rinsed them, and placed them in the resident's mouth.</p> <p>The record for Resident #F was reviewed on 7/17/12 at 2:00 p.m. The resident's diagnoses included, but were not limited to, atrial fibrillation (an irregular heart beat), hear failure, high blood pressure, and coronary artery disease.</p> <p>The 6/4/12 significant change Minimum Data Set (MDS) full assessment indicated the resident required extensive assistance of two staff members of transfers, bed mobility, and toileting. The assessment also indicated the resident required total</p>				

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	<p>assistance of staff for personal hygiene. A care plan initiated on 7/5/12 indicated the resident had an ADL self care deficit. Care plan interventions included for staff to turn and reposition the resident and provide the amount of assistance or supervision that is needed.</p> <p>When interviewed on 7/18/12 at 10:20 a.m., CNA #3 indicated she was not assigned to care for the resident until after breakfast and she was not assigned to for "get ups" for this resident.</p> <p>When interviewed on 7/18/12 at 1:20 a.m., CNA #1 indicated she was not assigned to care for Resident #F today. The CNA indicated she fed the resident his breakfast as she was assigned to room trays on the unit while the other staff were at breakfast. The CNA indicated CNA #3 was assigned to provide care to the resident. CNA #1 also indicated she had provided no other care for Resident #F other than feeding him this morning. The CNA indicated she had not provided incontinence care or repositioning for the resident on this day.</p> <p>When interviewed on 7/18/12 at 1:25 p.m., CNA #3 indicated she realized at lunch that she was assigned B hall. The CNA indicated she did not provide any care to Resident #F from the start of the</p>				

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	<p>shift at 6:00 a.m., until the time she and CNA #2 went in to put the resident on the bedpan.</p> <p>When interviewed on 7/18/12 at 1:30 p.m., RN#1 indicated she was the Nurse assigned to care for Resident #F. The RN indicated CNA#3 was assigned to care for the resident today.</p> <p>When interviewed on 7/19/12 at 2:40 p.m., the Director of Nursing indicated the resident should have received ADL (Activity of Daily Living) care in the morning.</p> <p>2. Resident D's record was reviewed 7/17/12 at 2:35 p.m. Resident D's diagnoses included but were not limited to congestive heart failure, atrial fibrillation, dementia, macular degeneration, muscle weakness, and insulin dependent diabetes.</p> <p>On 7/1/7/12 at 12:10 p.m., the resident was observed at her lunch table asleep with her food uncovered in front of her. At 12:15 p.m., the Admission Coordinator began feeding resident with strong encouragement.</p> <p>On 7/18/12 at 12:20 p.m., the resident was observed at her lunch table asleep with her food uncovered in front of her. LPN #1 was observed standing next to</p>						

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	<p>resident briefly and then walk away to another resident. No staff member stayed with resident to encourage her to eat or to feed her.</p> <p>During record review on 7/17/12 at 2:35 p.m., Resident K's Nutrition at Risk care plan on 5/30/12 indicated the resident had "...variable intakes of food/beverages...hx (history) of unplanned weight changes..." The interventions for the resident indicated "...Monitor/evaluate energy intake and/or food/beverage intake via meal intake records and observation...Allow resident sufficient time to eat...Provide feeding/dining assistance as needed..."</p> <p>A Social Service dated 5/31/12 at 4:16 p.m. indicated "...Eats in MDR (main dining room)-staff set up & (and) cue. Appetite 10-50% consumption. Wt (weight) 133.6 # (pounds) down (arrow pointing down) 3.4# x1 month..."</p> <p>The MDS (Minimum Data Set) Assessment completed on 5/31/12 indicated the resident required extensive assist for meals.</p> <p>This federal tag relates to Complaint IN00110790.</p> <p>3.1-38(a)(3)</p>			

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NAME OF PROVIDER OR SUPPLIER KINDRED NURSING AND REHABILITATION-BREMEN			STREET ADDRESS, CITY, STATE, ZIP CODE 316 WOODIES LN BREMEN, IN 46506		
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F0315 SS=G	<p>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER</p> <p>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>Based on record review and interview, the facility failed to obtain a urinalysis in a timely manner for a resident tensing and complaining of pain upon urination. This resulted in a delay in the treatment of a urinary tract infection for 1 of 3 residents reviewed for urinary tract infections in the sample of 12. (Resident #C) .</p> <p>Findings include:</p> <p>Resident #C's record was reviewed on 7/17/12 at 3:40 p.m. Resident #C's diagnoses included but were not limited to dementia, weakness, osteoarthritis.</p> <p>A care plan dated 4/19/12 indicated the resident displayed severely impaired decision making, rarely or never was understood when speaking, had difficulty following directions, and had trouble</p>	F0315	<p>It is the practice of this facility to ensure the highest quality of care is afforded our residents. Consistent with this practice, the following has been done: <i>The corrective action taken for the residents found to have been affected by the deficient practice was:</i>Resident C no longer resides at the facility. Therefore, no further corrective action could be taken for this resident. <i>The corrective action taken for those residents having the potential to be affected by the same deficient practice is:</i> All residents have the potential to be affected. All nurses have been in serviced on Condition Change of a resident. All residents with a UA completed since August 1, 2012 have been reviewed for treatment. <i>The measures put into place and a systemic change made to ensure the deficient practice does not recur is:</i> Licensed nursing staff has been educated relative</p>	08/19/2012	

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	<p>focusing. There were no care plans related to urinary tract infections.</p> <p>A nursing note on 4/28/12 at 2:50 p.m. indicated (Resident #C's) "Dgghts [sic] (daughter) was here and said that when (Resident #C) voids (urinates) he tenses (arrow pointing up) up, starts yelling. When daughter asked him if it hurts when he urinates, (Resident #C) said yes. MD (doctor) faxed req (requested) U/A (urinalysis)." At 3:00 p.m., the nursing note indicated the resident had "foul smelling urine" and "fluids encouraged." At 5:05 p.m., the nursing note indicated "order rcd (received) for U/A (urinalysis). No c/o (complaints)." A nursing note on 5/1/12 at 2:10 a.m. indicated "UA obtained per straight cath (catheter). Urine cloudy & (and) brownish. No (0 with line through it) odor." There was no documentation indicating why there was a delay in obtaining the ordered urinalysis.</p> <p>There was no documentation of any further assessment of the resident's above complaints of discomfort or any further documentation of any assessments of the resident's urine in the nursing notes between 4/28/12 and 5/1/12.</p> <p>Results of the 5/1/12 Urinalysis were positive for a large amount of occult blood and leukocytes. Bacteria and white</p>		<p>to no catheter/prevent UTI/ restore bladder including but not limited to, ensuring timely obtaining of physician orders, and timely completion of the orders received, including but not limited to obtaining of urine specimens. <i>To ensure the deficient practice does not recur, the monitoring system established is: A</i> Performance Improvement indicator has been established which evaluates compliance with timeliness of services on all shifts. The Director of Nursing or designee will complete indicator weekly for the first month, monthly for the first quarter and quarterly thereafter. Any identified concerns will be promptly addressed with responsible individual(s). The DNS/Designee will monitor the 24 Hour Report Sheets and during daily rounds with the nursing team to ensure residents requiring a UA have had the MD notified and UA obtained following the MD order. The results of the daily rounds will be monitored monthly for 3 months and reviewed in Monthly PI for 100 % compliance as determined at PI for further monitoring. DNS, or designee, will review results during the monthly performance improvement committee meeting to determine the need for continued monitoring or resolution</p>				

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	<p>blood cells were present. A Physician's order was written for the resident to receive Cipro (an antibiotic) 250 milligrams twice a day for 7 days. The final Culture and Sensitivity was reported to the facility on 5/4/12. The culture indicated the organism was resistant to the Cipro. The Cipro was discontinued and new orders were given for Macrobid (another type of antibiotic) 100 milligrams twice day for 7 days, and Keflex 250 milligrams four times a day for 7 days was ordered on 5/4/12.</p> <p>Interview with the ADON on 7/20/12 at 11:30 p.m. indicated she was unable to find faxes or documentation why there was a delay in the urinalysis.</p> <p>This federal tag relates to Complaint IN00110790.</p> <p>3.1-41(a)(2)</p>				

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F0323 SS=D	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>Based on observation, record review, and interview, the facility failed to provide adequate supervision related to not following guidelines/recommendations for swallowing precautions and leaving medications at the bedside for a resident with a diagnosis of swallowing difficulty for 2 of 2 residents reviewed for swallowing difficulties in the sample of 12. (Residents #F and #J).</p> <p>The facility also failed to ensure an evaluation was completed and safety prevention interventions were completed after an injury occurred with a wheel chair for 1 of 3 residents reviewed for falls in the sample of 12. (Resident #C)</p> <p>Findings include:</p> <p>1. On 7/18/12 at 8:45 a.m., Resident #F was observed in bed. CNA #1 entered the resident's room and started to set up the resident's meal tray. The resident was served pancakes, eggs, coffee, juice, and water that were all thickened. CNA #1</p>	F0323	<p>It is the practice of this facility to ensure the highest quality of care is afforded our residents. Consistent with this practice, the following has been done: <i>The corrective action taken for the residents found to have been affected by the deficient practice was:</i> Resident's J and F received appropriate care at the time of discovery during the survey. Resident C no longer resides at the facility. Therefore, no further corrective action could be taken for this resident. <i>The corrective action taken for those residents having the potential to be affected by the same deficient practice is:</i> All residents have the potential to be affected, thus, this plan of correction applies to all residents. All residents with swallowing Precautions have the potential to be affected. All residents with an injury have the potential to be affected. All residents with a swallowing precaution recommendation from the ST have had the swallowing precaution added to their tray cards for all staff to have when assisting with feeding the resident. PI was provided to the RN for leaving medications at</p>	08/19/2012			

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	<p>started feeding the resident at this time. The CNA gave the resident 3 bites of pancakes, then 5 sips of juice, then bites of pancakes. The CNA then gave the several more sips of juice and the resident finished the cup of juice. The CNA proceeded to give sips spoons of ice cream and then four sips of milk.</p> <p>A 7/13/12 Dysphagia Discharge Summary was reviewed. The Discharge Summary indicated Resident #F received Speech Therapy from 6/20/12 thru 7/13/12. The discharge recommendation on the Discharge Summary indicated the resident was to receive a mechanical soft diet with nectar thickened liquids and was to have close supervision. The Summary also indicated the resident was to have small bites and sips and also was to alternate solids/liquids every 1-2 bites.</p> <p>The 6/4/12 MDS (Minimum Data Set) significant change full assessment indicated the resident's BIMS (Brief Interview for Mental Status) score was 4. This indicated the resident cognitive patterns for decision making were severally impaired and the resident rarely or never made decisions. The assessment also indicated the resident required extensive assistance of staff for eating. The assessment also indicated resident demonstrated coughing or choking during</p>		<p>bedside. All residents with an injury have had the event reviewed for interventions to prevent accidents or injuries and the plan of care updated. <i>The measures put into place and a systemic change made to ensure the deficient practice does not recur is:</i> Nursing staff has been educated relative to accident hazards/supervision/devices including but not limited to, following guidelines/recommendations for swallowing precautions, not leaving medications at the bedside, and completion of post fall evaluations and safety prevention related to possible injury from wheel chair. <i>To ensure the deficient practice does not recur, the monitoring system established is:</i> A Performance Improvement indicator has been established which evaluates compliance with following guidelines/recommendations for swallowing precautions, not leaving medications at bedside, and completion of post fall evaluations across all shifts. The Director of Nursing or designee will complete indicator weekly for the first month, monthly for the first quarter and quarterly thereafter. Any identified concerns will be promptly addressed with responsible individual(s). The DNS/ED/Designee will audit tray cards weekly for Swallowing Precautions and monitor staff for</p>				

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	<p>meals or when swallowing medications.</p> <p>The resident care assignment sheet for the resident were received from the DON on 7/18/12 at 9:35 a.m. The sheet was dated 6/27/12. The DON indicated the sheets have care information related to each resident on the unit. The DON indicated this sheet was last updated on 6/27/12. The section for Resident #F was reviewed and indicated the resident was to receive nectar thickened liquids and straws were not to be used. The section also indicated the resident required total care from the staff.</p> <p>When interviewed on 7/18/12 at 9:05 a.m., CNA #1 indicated she was assigned to help feed the resident. The CNA was questioned on any specific instructions or precautions were in place for the resident's swallowing function and the CNA indicated the only instructions she was aware of were for the resident's liquids to be thickened and staff were not to use straws when feeding him liquids. The CNA indicated she was not aware of any ratio of bites and sips that were to be followed.</p> <p>When interviewed on 7/19/12 at 2:40 p.m., the DON indicated the therapy swallowing instructions should have been followed for feeding Resident #F.</p>		<p>implementing the swallow precautions appropriately weekly for a month then twice weekly for a month then monthly for a Quarter then quarterly all findings will be reviewed in monthly PI until 100% compliance is achieved. All events with an injury will be reviewed monthly in PI as an ongoing practice of this facility and monitoring will be for 100% compliance of response to events and implementation of interventions. DNS, or designee, will review results during the monthly performance improvement committee meeting to determine the need for continued monitoring or resolution.</p>		

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	<p>2. Resident C's closed chart was reviewed on 7/17/12 at 3:40 p.m. Resident C's diagnoses included, but were not limited to, dementia, weakness, and osteoarthritis.</p> <p>A care plan dated 4/19/12, indicated the resident displayed severely impaired decision making, rarely or never was understood when speaking, had difficulty following directions, and had trouble focusing. There were no care plans related to accidents noted.</p> <p>During this time, a nursing note on 6/7/12 at 9:30 p.m. indicated "Noted abrasion 1.5 x 1.7 x <0.1 cm (less than 0.1 centimeters) to RLE (right lower extremity) area red without (s with line above it) drainage...Caused while moving legs around leg set (and) pedal of w/chair (wheelchair). Will notify MD (medical doctor) et (and) POA (power of attorney)." A weekly non-pressure skin condition report on 6/7/12 indicated "faxed treatment". On 6/8/12 at 9:00 p.m., a nursing note indicated, "order rcd (received) for tx (treatment) RLE [sics] abrasion. POA aware..."</p> <p>Interview with the DON (Director of Nursing) and ADON (Assisted Director of Nursing) on 7/20/12 at 11:30 a.m., indicated they were unable to find an</p>	F0323	<p>It is the practice of this facility to ensure the highest quality of care is afforded our residents. Consistent with this practice, the following has been done: <i>The corrective action taken for the residents found to have been affected by the deficient practice was:</i> Resident's J and F received appropriate care at the time of discovery during the survey. Resident C no longer resides at the facility. Therefore, no further corrective action could be taken for this resident. <i>The corrective action taken for those residents having the potential to be affected by the same deficient practice is:</i> All residents have the potential to be affected, thus, this plan of correction applies to all residents. All residents with swallowing Precautions have the potential to be affected. All residents with an injury have the potential to be affected. All residents with a swallowing precaution recommendation from the ST have had the swallowing precaution added to their tray cards for all staff to have when assisting with feeding the resident. PI was provided to the RN for leaving medications at bedside. All residents with an injury have had the event reviewed for interventions to prevent accidents or injuries and the plan of care updated. <i>The measures put into place and a systemic change made to ensure the deficient practice does not</i></p>	08/19/2012	

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	<p>investigation report and documentation regarding implementation of interventions to prevent further injury.</p> <p>3. On 7/18/12 at 10:00 a.m., Resident J was observed to be behind a closed curtain farthest from the entrance door and was having difficulty swallowing her medication, indicated by pointing to her medication cup and her throat. The resident nodded her head yes and spoke "No can" when asked if she is having difficulty swallowing her medication. A pink oval pill, white round pill, and a small, beige, round pill was found at the bedside in a pill cup.</p> <p>At this time, RN #1 was interviewed and she indicated she was "taught that it is ok to leave pills if they know the resident will take their pills...She is the only one who I leave pills with." At 10:15 a.m., the DON was interviewed. She had indicated it is not the policy and she will inservice the staff immediately.</p> <p>The resident was observed eating in her room for lunch on 7/17/12 and breakfast and lunch on 7/18/12.</p> <p>Resident J's record was reviewed on 7/18/12 at 12:00 p.m. Resident J's diagnoses included but were not limited to type two diabetes, atrial fibrillation,</p>		<p><i>recur is:</i> Nursing staff has been educated relative to accident hazards/supervision/devices including but not limited to, following guidelines/recommendations for swallowing precautions, not leaving medications at the bedside, and completion of post fall evaluations and safety prevention related to possible injury from wheel chair. <i>To ensure the deficient practice does not recur, the monitoring system established is:</i> A Performance Improvement indicator has been established which evaluates compliance with following guidelines/recommendations for swallowing precautions, not leaving medications at bedside, and completion of post fall evaluations across all shifts. The Director of Nursing or designee will complete indicator weekly for the first month, monthly for the first quarter and quarterly thereafter. Any identified concerns will be promptly addressed with responsible individual(s). The DNS/ED/Designee will audit tray cards weekly for Swallowing Precautions and monitor staff for implementing the swallow precautions appropriately weekly for a month then twice weekly for a month then monthly for a Quarter then quarterly all findings will be reviewed in monthly PI until 100% compliance is achieved. All events with an</p>				

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	<p>congestive heart failure,dysphagia (difficulty swallowing), aphasia, and CVA (cerebral vascular accident/stroke).</p> <p>A "Medical Nutrition Therapy Assessment" was completed by the RD (Registered Dietitian) on 4/6/12. The RD indicated the resident had chewing/swallowing difficulties and was receiving a regular diet with liquids thickened to honey consistency. The RD also indicated nursing had reported the resident was needing increased assistance at meals. The RD also indicated the resident was noted to be pocketing (holding food in the cheek area) food at times.</p> <p>A Speech Therapy "Dysphagia Discharge Summary" completed on 7/13/12 indicated the resident was referred to Speech Therapy secondary to a decrease in her oral intake. The summary also indicated it was recommended that the resident go to the dining room for meals.</p> <p>A policy "Oral Medication Administration" dated 4/28/09, was provided by the DON on 7/18/12 at 11:15 a.m. The policy indicated "...Remain with the resident/patient and confirms that the medication has been taken...Documents the administration of medications immediately after seeing the resident take</p>		<p>injury will be reviewed monthly in PI as an ongoing practice of this facility and monitoring will be for 100% compliance of response to events and implementation of interventions. DNS, or designee, will review results during the monthly performance improvement committee meeting to determine the need for continued monitoring or resolution.</p>				

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	<p>the medications..."</p> <p>This federal tag relates to Complaint IN00111605.</p> <p>3.1-45(a)(2)</p>				

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F0502 SS=D	<p>483.75(j)(1) PROVIDE/OBTAIN LABORATORY SVC-QUALITY/TIMELY The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.</p> <p>Based on record review and interview, the facility failed to ensure a urinalysis was completed in a timely manner for 1 of 3 residents reviewed for urinary tract infections in the sample of 12. (Resident #C)</p> <p>Findings include:</p> <p>Resident #C's record was reviewed on 7/17/12 at 3:40 p.m. Resident #C's diagnoses included but were not limited to dementia, weakness, osteoarthritis.</p> <p>During this time, a nursing note on 4/28/12 at 2:50 p.m. had indicated Resident #C's "Dgghts [sic] (daughter) was here and said that when (Resident #C) voids (urinates) he tenses (arrow pointing up) up, starts yelling. When daughter asked him if it hurts when he urinates, (Resident #C) said yes. MD (doctor) faxed req (requested) U/A (urinalysis)." At 3:00 p.m., the nursing note indicated the resident had "foul smelling urine" and "fluids encouraged." At 5:05 p.m., the nursing note indicated "order rcd (received) for U/A. No c/o (complaints)."</p>	F0502	<p>It is the practice of this facility to ensure the highest quality of care is afforded our residents. Consistent with this practice, the following has been done: <i>The corrective action taken for the residents found to have been affected by the deficient practice was:</i> Resident C no longer resides at the facility. Therefore, no further corrective action could be taken for this resident. <i>The corrective action taken for those residents having the potential to be affected by the same deficient practice is:</i> All residents have the potential to be affected, thus, this plan of correction applies to all residents. All residents have the potential to be affected. All residents with an order for a LAB test since August 1, 2012 have been reviewed for compliance in obtaining the lab. Any findings have been reported to the MD and plan of care updated. <i>The measures put into place and a systemic change made to ensure the deficient practice does not recur is:</i> Nursing center licensed staff has been educated relative to administration, including but not limited to, ensuring timely obtaining of physician orders, and timely completion of the orders</p>	08/19/2012			

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(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>A nursing note on 5/1/12 at 2:10 a.m., "UA obtained per straight cath (catheter). Urine cloudy & (and) brownish. No (0 with line through it) odor." There was no documentation indicating why there was a delay in obtaining the ordered urinalysis.</p> <p>Interview with the ADON on 7/20/12 at 11:30 p.m., she was unable to find faxes or documentation why there was a delay in the urinalysis for Resident #C.</p> <p>This federal tag relates to Complaint IN00110790.</p> <p>3.1-49(a)</p>		<p>received, including but not limited to obtaining of urine specimens. <i>To ensure the deficient practice does not recur, the monitoring system established is:</i> A Performance Improvement indicator has been established which evaluates compliance with timeliness of services on all shifts. The Director of Nursing or designee will complete indicator weekly for the first month, monthly for the first quarter and quarterly thereafter. Any identified concerns will be promptly addressed with responsible individual(s). The DNS/Designee will monitor LAB orders 5 times weekly for compliance in obtaining labs for three months then twice weekly for 3 months then weekly as an on going practice of this facility. The results of the audits will be reviewed in the monthly PI for 100% compliance. DNS, or designee, will review results during the monthly performance improvement committee meeting to determine the need for continued monitoring or resolution.</p>	