

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155218	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/16/2012
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NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHABILITATION-DYER	STREET ADDRESS, CITY, STATE, ZIP CODE 2300 GREAT LAKES DR DYER, IN 46311
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F0000	<p>This visit was for the Investigation of Complaints IN00107792 and IN00108354.</p> <p>Complaint IN00107792-Substantiated. Federal/state deficiencies related to the allegations are cited at F225, F226, F309, and F323.</p> <p>Complaint IN00108354-Substantiated. No deficiencies related to the allegation are cited.</p> <p>Survey dates: May 14, 15, & 16, 2012</p> <p>Facility number: 000123 Provider number: 155218 AIM number: 100266720</p> <p>Survey team: Janet Adams, RN</p> <p>Census bed type: SNF/NF: 131 Total: 131</p> <p>Census payor type: Medicare: 31 Medicaid: 66 Other: 34 Total: 131</p>	F0000	<p>The facility requests that this plan of correction be considered its credible allegations of compliance.</p> <p>The facility also respectfully requests the consideration of paper compliance for the 4 citations outlined in this 2567.</p> <p>Submission of this response and Plan of Correction is not a legal admission that a deficiency exists or that this statement of deficiency was correctly cited and is also not to be construed as an admission of interest against the facility, the Administrator, or any employee, agents, or other individuals who draft or may be discussed in the response and Plan of Correction. In addition, preparation and submission of the Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the corrections of a conclusion set forth in this allegation by the survey agency.</p>	
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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>Sample: 16</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on May 21, 2012 by Bev Faulkner, RN</p>			

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F0225 SS=D	<p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>Based on record review and interview, the facility failed to ensure a fracture of</p>	F0225	F 225 What corrective action(s) will	06/04/2012			

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	<p>unknown origin was thoroughly investigated related to obtaining interviews from staff members caring for the resident for 1 of 1 investigations of fracture injuries of unknown origin reviewed. (Resident #P) (LPN #7) (CNA #4)</p> <p>Findings include:</p> <p>The closed record for Resident #P was reviewed on 5/16/12 at 9:00 a.m. The resident's diagnoses included, but were not limited to, pneumonia, muscle weakness, congestive heart failure, and osteoporosis. The resident was admitted to the facility on 1/18/12 and was discharged to another facility on 4/27/12.</p> <p>The 4/13/12 Minimum Data Set (MDS) quarterly assessment indicated the resident's cognitive skills for decision making were severely impaired and the resident rarely or never understood. The MDS assessment indicated the resident required extensive assistance of staff for bed mobility and eating and was independent with transfers. MDS Nurse #1 was interviewed on 5/16/12 and indicated the section for transfers was coded incorrectly. The MDS Nurse indicated the resident was not</p>				<p>be accomplished for those residents found to have been affected by the deficient practice?</p> <p>Resident #P has discharged from the facility. The other C.N.A was interviewed with no additional information provided with respect to the investigation.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken</p> <p>The facility has no other pending investigations at this time for injuries of unknown origin and/or abuse allegations.</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>Staff responsible for completion of investigations will be educated on completing investigations in a more thorough manner following the procedure outlined in the corporate policy entitled, "Conducting an Investigation".</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place</p>		

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	<p>independent with transfers and he required extensive assistance of staff for transfers.</p> <p>The 4/20/12 Progress Notes were reviewed. An entry made by LPN #7 at 11:12 a.m., indicated the resident's left elbow was noted with swelling and was hot to touch. No bruising was noted and the Nurse Practitioner on the unit was notified and orders were obtained for a stat X-ray to the left elbow.</p> <p>The 4/20/12 Nurse Practitioner note indicated the resident was observed up in the chair. Swelling was noted to the resident's left elbow extending down to the resident's distal 2/3 forearm, moderate erythema (redness) was noted at the elbow, and faint purplish/green ecchymosis to elbow.</p> <p>An X-ray of the left elbow was completed on 4/20/12. The results of the X-ray indicated a left elbow fracture was present at the distal humerus with mild displacement. Soft tissue swelling, joint effusion, and osteoporosis present. The conclusion noted on the X-ray report was "acute appearing distal humerus fracture as described."</p> <p>Review of the facility investigation of the resident's fracture indicated interviews</p>		<p>All internal investigations, ongoing will be completed in accordance with the facility policy and procedure.</p> <p>Investigations will be reviewed by the Performance Improvement Committee monthly to ensure that the corporate policy has been followed and that the investigations are complete.</p> <p>Results and system components will be reviewed by the PI Committee with subsequent plans of correction developed and implemented as deemed necessary.</p>				

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	<p>were obtained from a CNA, Occupational Therapy staff member, and an LPN. The investigation included the following written statements:</p> <p>A written statement was obtained from CNA #4. The statement indicated this CNA had taken care of the resident on 4/19/12 and 4/20/12 on the day shift. The CNA statement indicated she had taken care of the Resident #P on 4/19/12 and she dressed the resident and then she and CNA #5 got the resident out of bed with the Hoyer (mechanical device for lifting residents) and she did not notice any bruising or swelling. On 4/20/12 as she and CNA #5 got the resident up out of bed she noticed redness and "swallon" [sic] red elbow and the nurse was notified.</p> <p>A written statement by the Occupational Therapy staff member indicated he went into the resident's room on 4/20/12 and the resident was already in the geri chair. He started to provide range of motion to the resident's right arm and when he started to complete range of motion to the left arm he observed swelling and discoloration to the elbow area and reported this to the Nurse.</p> <p>A written statement by LPN #7 indicated on 4/20/12, a therapy staff member</p>						

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	<p>reported that Resident #P's left elbow was discolored. The statement indicated the LPN went into the resident's room to assess the resident and swelling was noted to the left elbow and the area was "hot" to touch. The Nurse Practitioner was notified and orders were given to obtain a stat X-ray.</p> <p>When interviewed on 5/16/12 at 10:25 a.m., CNA#4 indicated she was working and taking care of Resident #P on the day shift on 4/20/12. She indicated sometime after breakfast she and CNA #5 got Resident #P up in the Hoyer without problems or complaints of pain. The CNA was queried about dressing the resident and the CNA indicated the resident was already dressed in a long sleeve shirt and a brief by the night shift and "we then put his pants on and got him up in the gerichair." The CNA indicated there were no problems with the transfer. CNA #4 indicated about 5 minutes later therapy came to see the resident and noted swelling to the elbow.</p> <p>When interviewed on 5/16/12 at 10:35 a.m., the Director of Nursing indicated she was not aware the day CNA did not put the resident's shirt on that morning. The Director of Nursing indicated CNA's statement indicated she got the resident up and dressed that morning and she</p>						

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	<p>thought that would include putting the resident's shirt on. The Director of Nursing indicated she did not interview CNA #5 (the other CNA assisting with the resident's transfer on 4/20/12). The Director of Nursing indicated she had not interviewed any other staff caring for the resident or any staff from the night shift prior to the incident.</p> <p>The facility's Abuse Policy was reviewed on 5/15/12 at 4:00 p.m. The policy was dated 10/31/09. The policy indicated injuries of unknown origin are to be reported and investigated. An internal investigation was to be completed for all abuse allegations.</p> <p>When interviewed on 5/16/12 at 1:35 p.m., the facility Administrator indicated the investigation of the resident's fracture did not have any interview from other staff including the other CNA assisting with the transfer or any night staff members.</p> <p>This federal tag relates to Complaint IN00107792.</p> <p>3.1-28(d)</p>				

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F0226 SS=D	<p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES 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 record review and interview, the facility failed to follow their Abuse policy for investigating a fracture of unknown origin for 1 of 1 investigations of fractures of unknown origin reviewed. (Resident #P)</p> <p>Findings include:</p> <p>The closed record for Resident #P was reviewed on 5/16/12 at 9:00 a.m. The resident's diagnoses included, but were not limited to, pneumonia, muscle weakness, congestive heart failure, and osteoporosis. The resident was admitted to the facility on 1/18/12 and was discharged to another facility on 4/27/12.</p> <p>The 4/20/12 Progress Notes were reviewed. An entry made by LPN #7 at 11:12 a.m., indicated the resident's left elbow was noted with swelling and was hot to touch. No bruising was noted and the Nurse Practitioner on the unit was notified and orders were obtained for a stat X-ray to the left elbow.</p>			F0226	<p>F 226</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>Resident #P has discharged from the facility. The other C.N.A was interviewed with no additional information provided with respect to the investigation.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken</p> <p>The facility has no other pending investigations at this time for injuries of unknown origin and/or abuse allegations.</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>Staff responsible for completion of investigations will be educated</p>		06/04/2012

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	<p>The 4/20/12 Nurse Practitioner note indicated the resident was observed up in the chair. Swelling was noted to the resident's left elbow extending down to the resident's distal 2/3 forearm, moderate erythema (redness) was noted at the elbow, and faint purplish/green ecchymosis to elbow.</p> <p>An X-ray of the left elbow was completed on 4/20/12. The results of the X-ray indicated a left elbow fracture was present at the distal humerus with mild displacement. Soft tissue swelling, joint effusion and osteoporosis present. The conclusion noted on the X-ray report was "acute appearing distal humerus fracture as described."</p> <p>Review of the facility investigation of the resident's fracture indicated interviews were obtained from a CNA, Occupational Therapy staff member, and an LPN. The following statements were reviewed:</p> <p>A written statement was obtained from CNA #4. The statement indicated this CNA had taken care of the resident on 4/19/12 and 4/20/12 on the day shift. The CNA statement indicated she had taken care of the Resident #P on 4/19/12 and she dressed the resident and then she and CNA #5 got the resident out of bed with</p>		<p>on completing investigations in a more thorough manner following the procedure outlined in the corporate policy entitled, "Conducting an Investigation".</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place</p> <p>All internal investigations, ongoing will be completed in accordance with the facility policy and procedure.</p> <p>Investigations will be reviewed by the Performance Improvement Committee monthly to ensure that the corporate policy has been followed and that the investigations are complete.</p> <p>Results and system components will be reviewed by the PI Committee with subsequent plans of correction developed and implemented as deemed necessary.</p>				

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	<p>the Hoyer (mechanical device for lifting residents) and she did not notice any bruising or swelling. On 4/20/12 as she and CNA #5 got the resident up out of bed she noticed redness and "swallon" [sic] red elbow and the nurse was notified.</p> <p>A written statement by the Occupational Therapy staff member indicated he went into the resident's room on 4/20/12 and the resident was already in the geri chair. He started to provide range of motion to the resident's right arm and when he started to complete range of motion to the left arm he observed swelling and discoloration to the elbow area and reported this to the Nurse.</p> <p>A written statement by LPN #7 indicated on 4/20/12, a therapy staff member reported that Resident #P's left elbow was discolored. The statement indicated the LPN went into the resident's room to assess the resident and swelling was noted to the left elbow and the area was "hot" to touch. The Nurse Practitioner was notified and orders were given to obtain a stat X-ray.</p> <p>When interviewed on 5/16/12 at 10:25 a.m., CNA#4 indicated she was working and taking care of Resident #P on the day shift on 4/20/12. She indicated sometime</p>			

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	<p>after breakfast she and CNA #5 got Resident #P up in the Hoyer without problems or complaints of pain. The CNA was queried about dressing the resident and the CNA indicated the resident was already dressed in a long sleeve shirt and a brief by the night shift and "we then put his pants on and got him up in the gerichair." The CNA indicated there were no problems with the transfer. CNA #4 indicated about 5 minutes later therapy came to see the resident and noted swelling to the elbow.</p> <p>When interviewed on 5/16/12 at 10:35 a.m., the Director of Nursing indicated she was not aware the day CNA did not put the resident's shirt on that morning. The Director of Nursing indicated the CNA's statement indicated she got the resident up and dressed that morning and she thought that would include putting the resident's shirt on. The Director of Nursing indicated she did not interview CNA #5 (the other CNA assisting with the resident's transfer on 4/20/12). The Director of Nursing indicated she had not interviewed any staff caring for the resident on the night shift prior to the incident.</p> <p>The facility's Abuse Policy was reviewed on 5/15/12 at 4:00 p.m. The policy was dated 10/31/09. The policy indicated</p>			

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	<p>injuries of unknown origin are to be reported and investigated. An internal investigation was to be completed for all abuse allegations.</p> <p>When interviewed on 5/16/12 at 1:35 p.m., the facility Administrator indicated the investigation of the resident's fracture did not have any interview from other staff including the other CNA assisting with the transfer or any night staff members.</p> <p>This federal tag relates to Complaint IN00107792.</p> <p>3.1-28(a)</p>			

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F0309 SS=D	<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 ensure swallowing guidelines/strategies were followed for 2 of 4 residents reviewed for swallowing precautions in the sample of 16. (Residents #N & #M)</p> <p>Findings include:</p> <p>1. On 5/14/12 at 12:25 p.m., Resident #N was observed sitting in a wheel chair in the dining room on the South unit. The resident was served pureed food on a divided plate. The resident was also served a glass of apple juice. The resident was feeding himself numerous spoonfuls of the meal without taking a drink of the juice or any other beverage. The resident did not alternate bites of foods and liquids. Unit Manager #1 was observed sitting at the table with the resident and other residents. The resident was not instructed to alternate bites with swallows during the meal.</p>	F0309	<p>F 309</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>Swallowing precautions are now being followed for residents N an M.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken</p> <p>A full facility audit was completed to verify that all residents requiring swallowing precautions are being implemented as directed.</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>Education/in-service training has</p>	06/04/2012			

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	<p>On 5/15/12 at 8:25 a.m., Resident #N was observed sitting in a wheel chair in the dining room on the South unit. The meals trays had not arrived to the dining room at this time. Staff were pouring and serving beverages to residents in the dining room. CNA #3 served the resident a glass of juice. The resident had no meal tray or food served at this time. The resident began taking several drinks from the cup. The cart with the meals trays arrived to the dining room at 8:35 a.m.</p> <p>The record for resident #N was reviewed on 5/14/12 at 3:15 p.m. The resident's diagnoses included, but were not limited to, dementia and muscle weakness. The resident's current care plans were reviewed. A care plan, initiated on 2/10/12, indicated the resident had severe cognitive deficits and a history of PICA (consuming non-food items). The care plan was updated on 2/24/12 to indicate the resident tends to eat fast and shovels food in his mouth at times. Care plan interventions included for staff to provide one to one supervision at meals, never leave the resident unattended with food, and to alternate one bite solid/liquid.</p> <p>The CNA assignment sheet for the South unit residents was received from the Unit Manager on 5/15/12 at 11:10 a.m. The assignment sheet was dated 5/12/12. The</p>		<p>been completed for nursing staff related to the adherence of outlined swallowing precautions. Speech Therapists are to write any swallowing precautions as physician's orders. A copy of the swallowing precautions will then be placed in the C.N.A. /ADL book; meal consumption book and with the MAR for each resident requiring the same.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place</p> <p>Nurse management to randomly (3 X per week) audit residents who have swallowing precautions, across all 3 meals, to ensure precautions are being followed as ordered.</p> <p>Audit findings will be reported to the Performance improvement Committee monthly for 3 months and then quarterly to ensure ongoing compliance.</p> <p>Audit results and system components will be reviewed by the PI Committee with subsequent plans of correction developed and implemented as deemed necessary.</p>				

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	<p>Unit Manager indicated the sheet was the current one staff were using. The assignment sheet noted the resident was never to be left unattended with food and was to alternate liquids and solids.</p> <p>A Speech Pathology Evaluation was completed on 2/27/12. The evaluation indicated the resident was hospitalized 2/24/12- 2/25/12 for respiratory failure resulting choking aspiration. The resident's diet order prior to 2/24/12 was for a regular diet with thin liquids and the resident had no prior history of dysphagia (difficulty swallowing). The resident was to receive skilled Speech Therapy services for choking related to cognitive impairment. The Speech Pathology Weekly Progress Report for 2/28/12 through 3/5/12 indicated the resident was to have one to one supervision and one to one sip to bite.</p> <p>A Speech Pathology Discharge Summary was completed by and signed by the Speech Therapist on 3/19/12. The summary indicated the resident was to have a pureed diet with thin liquids and under the "Swallowing Strategies" section the author wrote "Refer to Aspiration."</p> <p>A Physician's Progress Note was written by the Nurse Practitioner on 2/24/12. The Progress Note indicated the Nurse</p>						

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	<p>Practitioner was asked to respond to a Code Blue. The resident was in the dining room eating and was found to be cyanotic (blue color to the skin from lack of oxygen) and was pulled onto the floor. The resident was non-breathing and CPR (cardio-pulmonary resuscitation) was initiated. Copious amounts of unchewed food was swept from the resident's mouth. The resident began to have sporadic spontaneous respirations and his pulse returned. EMS (ambulance staff) removed food from the resident's throat and the resident was transported to the hospital via EMS.</p> <p>Review of the 2/24/12 Resident Progress Notes indicated an entry was made by nursing on 2/24/12 at 12:18 p.m. The entry indicated the resident was in the South Dining Room feeding himself when a CNA observed the resident having difficulty swallowing food. The CNA notified the nurse who was present in the Dining Room also and the Heimlich (chest thrusts to attempt to expel food from the resident throat) was attempted and then the resident was moved to the floor and CPR was initiated, Code Blue and EMS were called. The 2/25/12 Resident Progress Notes indicated the resident returned to the facility at 6:30 p.m.</p>			

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	<p>When interviewed on 5/15/12 at 9:15 a.m., Speech Therapist #1 indicated Resident #N was on a regular diet and was able to feed himself when he first came in. The Speech Therapist indicated 911 emergency was called when the resident had a choking episode in the past and Speech Therapy services were started after the episode. The resident was placed on an aspiration protocol. The Speech Therapist indicated the resident was discharged from therapy and Aspiration Precaution Protocols were placed in the MAR (Medication Administration Record), the Dining Room book, and the CNA ADL(Activities of Daily Living) books on the unit. At this time, a review of the MAR book was conducted along with the Speech Therapist. Inside the MAR book there was a page titled, "Aspiration/Swallow Precautions" with Resident N's name. The precautions included for instructions for the resident never to be left alone during meals and he was to alternate liquids and solids.</p> <p>When interviewed on 5/15/12 at 2:40 p.m., the South Unit Manager indicated she was observing the resident during the lunch meal on 5/14/12. The Unit Manager indicated the resident was feeding himself and he was not instructed to alternate bites and drinks.</p>						

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	<p>2. On 5/15/12 at 11:55 a.m., Resident #M was observed sitting in Broda chair in the South Unit dining room waiting for lunch. The resident was served her meal tray at 12:29 p.m. The resident received a pureed diet served on a divider plate and a small can of ginger ale soda. LPN # 3 was standing next to the resident. The resident began feeding herself the food. The resident was able to scoop up spoonfuls of the pureed food and bring it to her mouth. The resident would fill the spoon with large amounts of food and quickly bring the spoon to her mouth. LPN #3 intervened multiple times by touching the resident's hand and instructing the resident to slow down and swallow her food. The LPN also scooped up a spoonful with a smaller amount of food on it and explained to the resident this was the amount of food she was to have at a time. The LPN did not ensure the resident alternated sips and bites throughout the meal.</p> <p>The record for Resident #M was reviewed on 5/15/12 at 10:00 a.m. The resident's diagnoses included, but were not limited to , cerebral vascular accident (stroke), diabetes mellitus, and depressive disorder. Review of the 5/2012 Physician Order Statement (POS) indicated an order was noted on 5/1/2012 for the resident to</p>						

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	<p>receive a pureed diet. A Nursing Alert for aspiration was noted on the POS.</p> <p>The 3/27/12 quarterly Minimum Data Set (MDS) assessment indicated the resident required extensive assistance from staff for eating. The MDS assessment also indicated the resident cognitive skills for decision making were impaired.</p> <p>The 5/10/12 Speech Pathology Discharge Summary was reviewed. The summary indicated the resident received therapy for increased coughing episodes with her mechanical soft diet. The recommendation on the summary indicated the resident was to have a pureed diet and was to have meals in a supervised dining room. The recommendations for swallowing strategies were to alternate liquids/solids (purred) 1:1 bite to swallow.</p> <p>When interviewed on 5/15/12 at 12:50 p.m., Speech Therapist #1 indicated the resident had received Speech Therapy and was recently discharged last week. She indicated the resident was currently on a pureed diet. The Speech Therapist indicated copies of the resident's swallowing precaution instructions were to be in the Nurses' MAR, dining room book, and the CNA ADL book. The above books were observed with the</p>			

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	<p>Speech Therapist at this time. A copy of the resident's "Aspiration/Swallow Precaution" sheet was not observed in the resident's MAR. There were copies in the ADL book and the Dining Book on the unit. The "Aspiration/Swallow Precautions" sheet for the resident indicated the resident was to alternate 1:1 bite to swallow.</p> <p>When interviewed on 5/15/12 at 2:40 p.m., the Director of Nursing indicated the Speech Therapist did not write orders to alternate bite and swallow for the resident as per the recommendation so it did not appear on the CNA assignment sheet for staff to be aware of the recommendations.</p> <p>This federal tag relates to Complaint IN00107792.</p> <p>3.1-37(a)</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 fall devices not in place for 1 of 3 residents reviewed for falls in the sample of 16. (Resident #D)</p> <p>Findings include:</p> <p>On 5/14/12 at 11:17 a.m., Resident #D was observed in a low bed. There was a green alarm box attached the right 1/4 side rail on the bed. There were no strings or cords attached to the alarm box. There were no visitors or staff in the resident's room at this time.</p> <p>On 5/14/12 at 2:32 p.m., the resident was observed in a low bed. There was a green alarm box attached the right 1/4 side rail on the bed. There were no strings or cords attached to the alarm box. There was a thin cord coming from under the resident's mattress and hanging under the resident's bed. CNA #1 and CNA #2 entered the resident's room at this time. The two CNA's used a lifter sheet on the</p>	F0323	<p>F 323 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? All fall related devices are in place for Resident D. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken Full facility audit of C.N.A. assignment sheets was completed to ensure preventative/assistive devices are current for all involved residents. Issues identified during this audit were immediately resolved. Room rounds conducted to ensure preventative/assistive devices were in place and designated alarms were functional as outlined on the C.N.A. assignment sheet. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur All direct care staff were re-educated on utilizing the C.N.A. assignment sheets to visually verify that all preventative/assistive devices are in place and functional. Staff were</p>	06/04/2012			

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	<p>resident's bed to pull the resident up in bed towards the head of the bed. The resident was lifted up off the bed mattress and no alarm sounded.</p> <p>On 5/15/12 at 7:50 a.m., the resident was observed sitting in a wheelchair in the hallway on the unit. The resident had a clip alarm attached to her with the cord attached to a green alarm box attached to the wheel chair.</p> <p>On 5/15/12 at 8:05 a.m., the resident's bed was observed in the high position. The resident was not in the bed at this time. There was a cord coming from underneath the bottom sheet on the resident's bed. The end of the cord was on the floor under the bed. The cord was not attached to any device and there was no alarm box under the resident's bed. Exposed wiring was noted at the end of the cord that was on the floor. There was no clip or attachment on the end of the cord that would clip into or attach to any alarm box.</p> <p>On 5/15/12 at 9:30 a.m., the resident was observed in her low bed. There was a green alarm box attached the right 1/4 side rail on the bed. There were no strings or cords attached to the alarm box. There was a thin cord coming from under the resident's mattress and hanging under</p>		<p>also informed that failure to comply with ensuring care is provided according to the directives outlined on the C.N.A. assignment sheets will result in disciplinary action to include possible termination. In addition to the Unit Managers verifying compliance via direct observation, facility department managers will also validate the placement of preventative/assistive devices as stated on the C.N.A. assignment sheets through random room rounds five times weekly to encompass all shifts. Central Supply Clerk and/or designee will check placement and functioning of all alarms weekly. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place</p> <p>PI tool related to the assurance that preventative/assistive devices are in place as ordered will be completed by facility management on all residents 3 times weekly for a month; monthly for a quarter ; and then quarterly thereafter to ensure ongoing compliance. Audit findings to be reported to the Performance Improvement Committee monthly for 3 months and then quarterly to ensure ongoing compliance. Audit results and system components will be reviewed by the PI Committee with subsequent plans of correction developed and</p>				

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	<p>the resident's bed. There were no staff members or visitors in the resident's room at this time.</p> <p>On 5/15/12 at 9:31 a.m., a request was made of Unit Manager #1 to enter Resident #D's room. The Unit Manager indicated the resident's fall devices included a low bed, floor matt, and the use of a bed alarm. The Unit Manager then examined the alarm box on the bed rail and indicated the alarm cord should have been connected to the box. The Unit Manager then observed the alarm pad that was under the resident's bed sheet and noted the cord from the bed was hanging under the resident's bed onto the floor and not attached to anything. The cord observed on the floor had torn wires noted at the end and had no clip in place.</p> <p>When interviewed on 5/15/12 at 9:35 a.m., LPN #2 indicated she had assisted Resident #D into bed after breakfast. The LPN indicated the alarm box should have been attached when she placed the resident into her bed.</p> <p>When interviewed on 5/15/12 at 9:45 a.m., Unit Manager #1 indicated the alarm was not functioning and needed to be replaced.</p> <p>The record for Resident #D was reviewed</p>		implemented as deemed necessary.				

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	<p>on 5/14/12 at 2:00 p.m. The resident's diagnoses included, but were not limited to, dementia with behaviors, psychosis, anxiety, heart disease, and depressive disorder. The 5/2012 Physician Order Sheet was reviewed. There were Physician orders for the resident to be in a low bed and a bed alarm to be in place.</p> <p>A Minimum Data Set (MDS) quarterly assessment was completed on 4/10/12. The MDS assessment indicated the resident required extensive assistance of one staff member for transfers. The assessment also indicated a BIMS assessment (resident interview for cognitive status) indicated the resident's cognitive patterns were severely impaired.</p> <p>A care plan initiated on 1/13/12 indicated the resident's physical mobility was impaired related to falls, weakness, and an unsteady gait. Care plan approaches included for the resident to have bed and wheel chair alarms in place and a low bed with a mat placed on the floor.</p> <p>The CNA assignment sheet for the South unit residents was received from the Unit Manager on 5/15/12 at 11:10 a.m. The assignment sheet was dated 5/12/12. The Unit Manager indicated the sheet was the current one staff were using. The assignment sheet indicated the resident</p>			

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	<p>was to have bed and wheel chair alarms in place.</p> <p>When interviewed on 5/15/12 at 5:00 p.m., the Director of Nursing indicated the resident's bed alarm should have been in place and working as ordered by the Physician.</p> <p>This federal tag relates to Complaint IN00107792.</p> <p>3.1-45(a)(2)</p>				