

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155704	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  03/20/2013
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NAME OF PROVIDER OR SUPPLIER  WALDRON HEALTH AND REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 505 N MAIN ST WALDRON, IN 46182
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: March 13, 14, 15, 18, 19 and 20, 2013</p> <p>Facility number: 000423 Provider number: 155704 AIM number: 100290450</p> <p>Survey team: Karina Gates, BHS TC Courtney Mujic, RN Beth Walsh, RN Gloria Bond, RN (March 13, 14 and 15, 2013)</p> <p>Census bed type: SNF/NF: 64 Total: 64</p> <p>Census payor type: Medicare: 18 Medicaid: 37 Other: 9 Total: 64</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review 3/26/13 by Suzanne Williams, RN</p>	F000000	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.	
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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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F000159 SS=B	<p>483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS</p> <p>Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section.</p> <p>The facility must deposit any resident's personal funds in excess of \$50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.)</p> <p>The facility must maintain a resident's personal funds that do not exceed \$50 in a non-interest bearing account, interest-bearing account, or petty cash fund.</p> <p>The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf.</p> <p>The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident.</p> <p>The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative.</p> <p>The facility must notify each resident that</p>				

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	<p>receives Medicaid benefits when the amount in the resident's account reaches \$200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI.</p> <p>Based on interview, observation and record review, the facility failed to offer week-end banking hours for residents to access their personal funds. This affected for 3 of 4 residents interviewed with a personal funds account and potentially affected 29 residents in the facility with a personal funds account. (Residents #22, #21 and #2)</p> <p>Findings include:</p> <p>During an interview with Resident #22 on 3/14/13 at 1:34 p.m. regarding whether she could get money from her personal funds account on the weekend, she indicated, "They are closed on the weekends. If you don't tell them before the weekend, you can't get it."</p> <p>During an interview with Resident #21 on 3/14/13 at 3:22 p.m. regarding whether she could get money from her personal funds account on the weekend, she indicated, "They aren't</p>	F000159	<p>Banking hours for residents are posted for each weekday, Monday through Friday. Effective April 15, 2013, Waldron Health &amp; Rehab Center will implement a practice for residents to access their personal funds seven days a week. The resident council was informed on March 26, 2013 that a new practice for accessing funds on the weekends would be implemented. This information will be reviewed at the next scheduled resident council meeting on April 29, 2013.</p> <p>Resident trust funds will be available seven days per week. The administrator or designee will audit this practice weekly for 4 weeks, then monthly for three months, then quarterly through March 31, 2014. Audit results will be presented to the Quality Assessment and Assurance Committee monthly for 3 months and then quarterly through March 31, 2014, with a subsequent plan developed and implemented as necessary. Completion date April 15, 2013.</p>	04/15/2013

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	<p>open on the weekends."</p> <p>During an interview with Resident #2 on 3/14/13 at 12:49 p.m. regarding whether she could get money from her personal funds account on the weekend, she indicated, "They're closed on Saturday and Sunday. Can't even get a dollar."</p> <p>During an interview with the Business Office Manager on 3/19/13 at 12:22 p.m., she indicated the banking hours at the facility were 8:00 a.m. to 4:30 p.m., Monday through Friday. A sign was observed at this time, posted at the front desk that indicated business hours were Monday through Friday from 8:30 a.m. to 5:00 p.m., except holidays.</p> <p>On 3/19/13 at 12:38 p.m. the Executive Director indicated there were no weekend banking hours. The Executive Director indicated if a resident needed money on the weekend, they could ask the manager on duty and the manager would have to contact the Assistant Business Office Manager on her personal phone in order to access it.</p> <p>3.1-6(f)(1)</p>			

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F000241 SS=D	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Based on observation, interview and record review, the facility failed to ensure a resident was spoken to with dignity by a staff member for 1 of 3 residents reviewed for dignity of 3 who met the criteria for dignity. (Resident #38)</p> <p>Findings include:</p> <p>The clinical record for Resident #38 was reviewed on 3/19/13 at 11:30 a.m.</p> <p>The diagnoses for Resident #38 included, but were not limited to: dementia.</p> <p>During a lunch observation on 3/14/13 at 11:50 a.m., Resident #38 asked if she had anything on her face 3 consecutive times as she wiped her mouth with a cloth napkin.</p> <p>Upon entrance to Resident #38's room on 3/14/13 at 12:58 p.m., she asked 4 consecutive times if her lipstick looked okay.</p>	F000241	<p>Waldron Health &amp; Rehab Center recognizes the importance of treating each resident in a manner that maintains or enhances his or her dignity and respect. As noted in this document, CNA #7 was inserviced on March 19, 2013 regarding speaking to residents in a manner that is respectful. Resident #38 has had no negative affects from the alleged failure to be spoken to in a dignified manner. All residents have the potential to be affected by the alleged deficient practice. Staff was inserviced on resident dignity at meetings held April 1-3, 2013. Each staff member was quizzed following the inservice to validate understanding of the facility expectations for interacting with residents. The administrator or designee will interview at least 6 alert and oriented residents weekly for 4 weeks then monthly for 3 months then quarterly through March 31, 2014. All potential negative interactions will be investigated. Findings will be reviewed by the Quality Assessment and Assurance Committee monthly for 3 months and then quarterly through March</p>	04/15/2013			

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	<p>An interview was conducted with Resident #80, the roommate of Resident #38, on 3/14/13 at 12:58 p.m. Resident #80 indicated a staff person was rude to Resident #38 a few days prior, regarding Resident #38 asking the staff person a question repeatedly.</p> <p>During an interview with a family member of Resident #38 on 3/15/13 at 11:27 a.m., regarding whether staff treat Resident #38 with respect and dignity, she indicated a staff member was rude to Resident #38 after asking the staff member 3 times what time it was.</p> <p>The 3/12/13 Incident Report and investigative documentation regarding the above incident was provided by the ED (Executive Director) on 3/18/13 at 3:30 p.m. The Incident Report indicated, "Brief Description of Incident: (Name of Resident #80) reported to Business Office Manager (name of Business office Manager) that she had cussed out a nurse for the way the nurse treated her roommate (name of Resident #38). Through initial investigation, (name of Resident #80) described CNA (name of CNA #7) rather than a nurse."</p>		31, 2014, with a subsequent plan developed and implemented as necessary. Completion Date April 15, 2013.		

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	<p>The 3/12/13 Interview/Investigative Record of interviewee CNA #7 indicated, "At 4 AM I did a bed check on (name of Resident #38). (Name of Resident #38) asked what time it was. I told her 4 AM. (Name of Resident #38) again asked the time. I said I just told you, it's 4 AM..."</p> <p>The 3/12/13 Interview/Investigative Record of interviewee Resident #80 indicated, "(Name of CNA #7) asked (name of Resident #38) what time it was. (Name of CNA #7) said, "I just told you." (Name of Resident #38) said, "No you didn't." (Name of CNA #7) said, "I did too..."</p> <p>During an interview with the ED on 3/19/13 at 1:05 p.m. regarding whether she thought CNA #7's response "I just told you." was appropriate, given Resident #7's medical condition, she indicated, "Is it the best thing? That's probably a judgement call. It's probably not what I would have said. When she repeats herself to me, I complement her." She indicated CNA #7 was not inserviced as a result of this incident.</p> <p>On 3/20/13 at 10:45 a.m., the ED provided a copy of the 3/19/13 Reminder Inservice for All Employees</p>			

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	<p>regarding standards of conduct. It indicated, "Reviewed above standards of conduct with CNA (name of CNA #7). Discussed resident perception of discussions and talk while care is provided. Encouraged (name of CNA #7) to practice being aware of her words and tone while providing care." It was signed by the ED, Director of Staff Development, and CNA #7.</p> <p>3.1-3(t)</p>			

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F000282 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 interview and record review, the facility failed to ensure a resident had her blood pressure taken daily and a resident's dental recommendations were acknowledged and addressed in accordance with their plans of care for 2 of 21 residents reviewed for following plans of care. (Resident #21 and #22)</p> <p>Findings include:</p> <p>1. The clinical record for Resident #21 was reviewed on 3/18/13 at 11:45 a.m.</p> <p>The diagnoses for Resident #21 included, but were not limited to: hypertension.</p> <p>The November, 2009 hypertension care plan for Resident #21, with a goal date of May, 2013, indicated approaches were Toprol XL50mg daily and to monitor blood pressure.</p> <p>The March, 2013 Physician Orders for Resident #21 indicated Toprol</p>	F000282	<p>It is the practice of the facility to provide services by qualified persons in accordance with each resident's written plan of care. 1. Residents 21 and 22 were assessed by nursing and Primary Care Provider. They were found to have no adverse effects from the alleged deficient practice. Resident 22's dentist was contacted for clarification of the recommendations. Their plans of care have been reviewed and revised as needed.2. Residents with recommendations from dental visits and specific physician orders for Blood Pressure (B/P) monitoring have the potential to be effected by the alleged deficient practice. Dental visit progress notes for the previous 60 days have been reviewed to ensure recommendations have been implemented with plan of care updated as appropriate. 3. Facility staff have been re-educated on expectations for review of progress notes and following physician's orders and the resident's plan of care. Inservices were held April 1-3, 2013.4. Progress notes from the dentist will be reviewed by the Director of Nursing or designees</p>	04/15/2013	

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	<p>XL50 mg tab to be taken by mouth daily at 6:00 a.m. and to hold the medication if her systolic blood pressure was less than 100.</p> <p>The March, 2013 MAR (medication administration record) for Resident #21 indicated the above medication was given daily, but no blood pressure readings were indicated.</p> <p>During an interview with the Director of Staff Development on 3/19/13 at 12:42 p.m. she indicated she did not see that Resident #21's blood pressures were taken daily, but that they should be in order to give the medicine since it shouldn't be given if the systolic blood pressure was less than 100. She indicated Resident #21's blood pressures were taken weekly and the readings could be found in the computer.</p> <p>At 1:00 p.m. on 3/19/13, the Director of Staff Development provided a printout of Resident #21's March, 2013 blood pressures. It indicated blood pressure readings for 3/5/13 and 3/12/13 only.</p> <p>2. The clinical record for Resident #22 was reviewed on 3/18/13 at 2:00 p.m. It indicated Resident #22 was on oxygen therapy.</p>		<p>for specific recommendations to ensure recommendations are followed and plan of care updated to include interventions to address the recommendations. .</p> <p>Director of Nursing will review 50% of dentist's progress notes and physician ordered B/P monitoring documentation for one month and then 10% for 3 months. Results will be reported to the Quality Assessment and Assurance Committee monthly for 3 months and then quarterly through March 31, 2014, with a subsequent plan developed and implemented as necessary. Completion Date: April 15, 2013</p>				

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	<p>The diagnoses for Resident #22 included, but were not limited to: hypertension.</p> <p>Review of the 11/14/12 dental progress note for Resident #22 indicated, "Oral exam and cleaning of medium level accumulations around remaining teeth. 02 (oxygen) therapy dries mouth and facilitates cervical calculus formation." The 2/27/13 dental progress note indicated, "Oral exam and cleaning of medium level accumulations. Rx (prescription) improve daily oral hygiene."</p> <p>During an interview with LPN #4 on 3/18/13 at 2:22 p.m. regarding what had been done as a result of the 2/27/13 dental recommendation, she indicated the CNAs (Certified Nursing Assistants) "set her up at her bedside table", but she didn't recall the 2/27/13 dental recommendation.</p> <p>During an interview with the DON (Director of Nursing) on 3/18/13 at 2:30 p.m. she indicated she was unaware of the 2/27/13 dental progress note for Resident #21 and that clarification was needed as to what the dentist meant by it. She stated, "We'll also need to see if he wrote a prescription for any other</p>			

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	<p>residents in the progress notes. If I had known this prescription was here on 2/27/13, I would maybe use more cueing for her, analyze the type of paste, whether she needs a rinse. Now that I know, I will change her ADL (activities of daily living) care plan from set up to actual supervision." She indicated she did not get an actual prescription for any of the residents when the dentist left the facility on 2/27/13. She indicated her expectation was for the Social Services Department to get clarification from the dentist when he came in as to the procedures for any recommendations, especially since he was new to the facility. She stated, "I'm not sure what happened."</p> <p>3.1-35(g)(2)</p>			

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F000315 SS=D	<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 observation, interview, and record review, the facility failed to provide a medical justification for the continued use of a urinary catheter for 1 of 3 residents reviewed for urinary catheter usage out of 17 residents who met the criteria for urinary catheter usage. Resident #66.</p> <p>Findings include:</p> <p>Resident #66's clinical record was reviewed on 3/19/2013 at 11 am. Resident #66 was admitted to the facility on 11/7/2012. Diagnoses included, but were not limited to; traumatic brain injury, acute kidney failure, anemia, dysphagia, neurogenic pruritus (itchiness), insomnia, history of urinary tract infections, depressive disorder, pneumonia, palliative care.</p>	F000315	<p>It is the practice of the facility to 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. 1. Resident 66 was assessed by nursing and Primary Care Provider. He was found to have no adverse effects from alleged deficient practice. His need for continued use of indwelling catheter has been assessed and diagnosis list updated to include appropriate diagnosis by his Primary Care Provider. 2. Residents with indwelling catheters have the potential to be affected. Residents with indwelling catheters currently in house has been reviewed to ensure continued need and medical records includes appropriate diagnosis for use of indwelling catheter 3. Nursing staff have been re-educated on medical necessity for the usage</p>	04/15/2013			

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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>An MD progress note, dated 11/27/2012 at 10:10 am, indicated, "Genitourinary: He does have Foley catheter in...."</p> <p>A quarterly review MDS (minimum data set) assessment dated 1/30/2013 indicated, "Appliances: Indwelling catheter (including suprapubic catheter and nephrostomy tube)" the answer was checked, "Yes".</p> <p>During observation of the lunch meal in the main dining room on 3/19/2013 at 11:30 am, the resident had a urinary catheter.</p> <p>An interview with LPN #4, on 3/20/2013 at 10:50 am, indicated Resident #66 still has the urinary catheter; he was admitted with it. She indicated she doesn't know exactly why he has the catheter. At 11:10 am, LPN #4 indicated she looked in the resident's chart, and the reason he has it, is because he has kidney disease.</p> <p>A "Catheter need evaluation and care plan", dated 11/1/2012, indicated, "Problem: High risk for urinary tract infection due to: indwelling catheter. For the following Clinical Reason(s)"; (None of the following were</p>		<p>of indwelling catheters. Inservices were held April 1-3, 2013.4. The Director of Nursing or Designee will monitor the medical record of residents with catheters monthly for appropriate necessity and appropriate diagnosis. Results will be reported to the Quality Assessment and Assurance Committee monthly for 3 months and then quarterly through March 31, 2014, with a subsequent plan developed and implemented as necessary. Date of completion: April 15, 2013</p>		

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	<p>check-marked in the boxes next to the reasons;) "Urinary Retention that cannot be treated or corrected medically or surgically, with documented PVR (post void residual) Volume(s) &gt;200 ml, inability to manage the retention with Intermittent Cath's, persistent over-flow Incontinence, symptomatic infections, and/or renal dysfunction. Stage III or Stage IV Pressure Ulcer which has been contaminated by urine and has resulted in impeded or delayed healing. Terminal illness or other severe impairment which; makes positioning or clothing changes uncomfortable, with; associated intractable pain or discomfort."</p> <p>An interview with the Director of Nursing (D.O.N.) on 3/20/2013 at 1:40 pm indicated she cannot find any documentation related to the medical justification for the resident's urinary catheter. She called the previous facility where the resident used to live and was awaiting feedback from them regarding why he has the catheter.</p> <p>3.1-41(a)(2)</p>			

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F000323 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. Based on interview and record review, the facility failed to ensure wheelchair brakes were locked prior to a transfer, resulting in a fall, and to consider non-skid footwear as an intervention following a fall, for 2 of 3 residents reviewed of 4 who met the criteria for accidents. (Resident #95 and #32)</p> <p>Findings include:</p> <p>1. Resident #95's clinical record was reviewed on 3/19/2013 at 2:30 pm. Diagnoses included, but were not limited to; acute urinary tract infection, dementia, depression, anxiety, osteoarthritis.</p> <p>A nursing progress note, dated 3/7/2013 at 3:57 am, indicated, "Time of incident: 2:45 am...Assisted or controlled fall by writer from bed which occurred during: self-transfer...Possible Contributing Factors: footwear-barefoot/socks/shoes sliding of positioning issue restlessness or</p>	F000323	<p>It is the practice of the facility to 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. 1. Residents 95 and 32 were assessed by nursing and found to have no adverse effects from alleged deficient practice. 2. Residents at risk for falls have the potential to be effected by the alleged deficient practice.3. Facility nursing staff re-educated on wheelchair transfer techniques and slip/fall prevention. Inservices were held April 1-3, 2013. 4. The Interdisciplinary Team will match CNA worksheets, Care Plans and resident interventions during Interdisciplinary Team Rounds to ensure that each resident has the proper fall prevention items according to his or her care plan. The IDT will report results to the Quality Assessment and Assurance Committee monthly for 3 months and then quarterly through March 31, 2014, with a subsequent plan developed and implemented as necessary.Date of completion: April 15, 2013</p>	04/15/2013			

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	<p>anxiousness...Equipment involved: resident had one hand on unlocked bedside table and one hand on unlocked wheelchair witnessed by LPN #5. Injury: resident has no complaints. Subjective or resident: lost balances, and stated, "I thought I would feel better if I were just able to get up"...no injury, no pain...Request/suggestion: may need to consider low bed with mat. Comments:...writer entered the room to find resident leaned against bed with one hand on rolling bedside table and one hand on unlocked wheelchair. As writer approached, residents socks slipped and due to her unsafe handles she began to fall forward..."</p> <p>A care plan, dated 11/12/2012, indicated, "Fall risk care plan: Problem: At risk for falls and injuries. Interventions:...dated 3/7/13: bed alarm; chair alarm."</p> <p>A "IDT (interdisciplinary team) Post-Occurrence Assessment and Plan Review", dated 3/7/2013, indicated, "Briefly Describe Occurrence Under Review; Extent or Nature of Any Injuries: Res (resident) walking while holding on to over bed table and unlocked w/c. (wheelchair) Started to fall and staff lowered to</p>				

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	<p>floor. Factors Contributing to Device Use: decreased safety awareness d/t (due to) decreased cognition. Review Safety Devices in Use or those Potentially in Need Related to this Occurrence": (The space after this question was blank.) "IDT Notes/ Recommendations/ Targeted Plan to Prevent Recurrence:...Will request bed alarm related fall [sic]. Cont. (continue) to participate with occupational and physical therapy and speech."</p> <p>An interview with the Director of Nursing (D.O.N.), on 3/18/2013 at 1:53 pm indicated her expectation of staff is to make sure the residents have on appropriate footwear.</p> <p>An interview with the D.O.N., on 3/19/2013 at 2:20 pm, indicated she was not sure why non-skid footwear wasn't considered as it should be. The D.O.N. indicated the resident has done really well so far with the alarms; they hardly ever set off. The alarms were chosen rather than putting the resident in a low bed with mat because she is in a large bariatric bed, and they felt that the switch to a more narrow bed would not be helpful and actually cause more falls. The D.O.N. indicated the alarms don't seem to bother the resident.</p>						

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	<p>2. The clinical record for Resident #32 was reviewed on 3/18/13 at 11:30 a.m. The diagnoses for Resident #32 included, but were not limited to: hypertension, depression, and failure to thrive.</p> <p>During an interview with LPN #1 on 3/13/13 at 1:27 p.m. she indicated Resident #32 had a fall on 3/13/13 because the wheelchair brakes were not locked on one side and the wheelchair moved away from the Resident when the Resident was attempting to sit in the wheelchair, resulting in a fall.</p> <p>A review of a Nurse's Note, on 3/13/13 at 4:56 p.m., indicated Resident #32 had a witnessed fall, by CNA #2, at 10:00 a.m. Resident #32 was in a standing position, attempting to sit in a wheelchair. One side of the wheelchair was locked and the other side of the wheelchair was not locked. The Nurse's Note also indicated, when Resident #32 attempted to sit down in wheelchair, the wheelchair rolled backwards and the resident fell on their buttocks and hit their head on a walker that was next to the wheelchair.</p> <p>An IDT (inter-disciplinary team) note,</p>			
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	<p>dated 3/14/13, received from the DoN (Director of Nursing), on 3/19/13 at 11:30 a.m., indicated, "CNA only had one brake locked on w/c (wheelchair) -w/c slid when resident went to sit down."</p> <p>On 3/18/13, at 1:53 p.m., the DoN (Director of Nursing) indicated wheelchair wheels need to be locked, prior to a transfer to/from a wheelchair.</p> <p>A review of a policy, titled, "Transfer Activities," received from the DoN on 3/18/13, at 2:09 p.m., indicated in, General Instructions..."2. Lock wheel chair [sic] brakes and lift foot rests."</p> <p>3.1-45(a)(2)</p>			

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F000371 SS=F	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, interview and record review, the facility failed to ensure hot foods served from the steam table were at or above 135 degrees Fahrenheit upon serving and that foods stored in the refrigerator were properly contained. This had the potential to affect 63 of 63 residents served food from the kitchen.</p> <p>Findings include:</p> <p>A tour of the kitchen was conducted on 3/20/13 at 11:10 a.m.</p> <p>The refrigerator was observed with a container of leftover pork steak dated 3/18/13, with a use by date of 3/20/13. The lid to the container had a 2 inch crack in the corner and exposed the food to air. The lid did not fit securely onto the container, rather was resting on top of it. Next to the left over pork steak was a container of left over tossed salad dated 3/18/13, with a use by date of</p>	F000371	<p>It is the practice of the facility to: <u>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions.</u> All residents have the potential to be affected by the alleged deficient practices. The improperly fitting storage lids were discarded on March 20, 2013. New storage lids were ordered. New spillage pans were ordered and put into use to maintain required temperatures for hot foods. Dietary staff were inserviced on April 12, 2013 on proper storage of food and maintaining required temperatures of hot foods. The Dietary Manager or designee will check and record temperatures of hot foods at least one meal per day for the next 30 days then at least one meal per week through March 31, 2014. Temperatures below the indicated temperature for hot products will result in immediate correction. The Registered Dietician will review temperature records at least once per week for 30 days then at least once per month through March</p>	04/15/2013	

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	<p>3/20/13. Again, the lid did not fit securely onto the container, rather was resting on top of it, exposing the salad to air. The Dietary Manager took the containers of salad and pork steak, threw the lids away, and stated, "We need new containers."</p> <p>On 3/20/13 at 11:50 a.m. food temperatures were taken by the Dietary Manager at the steam table during the lunch service and indicated the following:</p> <p>pureed green beans -110 degrees Fahrenheit ground chicken -126 degrees Fahrenheit baked potato -130 degrees Fahrenheit chicken - 118 degrees Fahrenheit</p> <p>During an interview with the Registered Dietician on 3/20/13 at 11:50 a.m. regarding the above temperatures, she indicated she expected them to be over 135 degrees Fahrenheit. She stated, "I have a problem with all the temperatures under 135."</p> <p>The policy for food temperatures and storage was provided by the Dietary Manager on 3/20/13 at 12:00 p.m. It indicated temperatures for hot</p>		<p>31, 2014 for audit purposes. The Dietary Manager will report results to the Quality Assessment and Assurance Committee monthly for 3 months and then quarterly through March 31, 2014, with a subsequent plan developed and implemented as necessary. Date of Completion: April 15, 2013</p>		

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	<p>products should be 135 degrees Fahrenheit or above and appropriate serving temperatures to residents was over 135 degrees Fahrenheit for hot foods. It also indicated, "Store items in the refrigerator so air circulates well around the pans to ensure proper cooling."</p> <p>3.1-21(i)(3)</p>			

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F000514 SS=D	<p>483.75(I)(1) RES RECORDS-COMPLETE/ACCURATE/ACCE SSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on interview and record review, the facility failed to ensure medication was documented completely, for 2 of 10 residents reviewed for unnecessary medications. (Resident #43 and #37)</p> <p>Findings include:</p> <p>1. The clinical record for Resident #43 was reviewed on 3/19/13 at 10:40 a.m. The diagnoses for Resident #43 included, but were not limited to: chronic stage IV sacral decubitus, protein calorie malnutrition, and renal failure.</p> <p>A recapitulation of the March Physician's Orders indicated Resident #43 was to receive Accuchecks (blood sugar monitoring) four times</p>	F000514	<p>It is the practice of the facility to maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete and accurately documented.1. Residents 43 and 37 were assessed by nursing and Primary Care Provider. They were found to have no adverse effects from alleged deficient practice. Their diabetes management regimens were reviewed by the Primary Care Provider.2. Residents with physician's orders for sliding scale insulin have the potential to be effected by the alleged deficient practice.3. Facility nursing management reviewed and revised the procedure for documentation of sliding scale insulins to provide clarity for nurses both in administration and documentation. Facility nursing staff has been inserviced on the</p>	04/15/2013			

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	<p>daily. The Physician's Orders also indicated Novolog (insulin) was to be given on a sliding scale. The Novolog sliding scale was 151-200=2 units of Novolog, 201-250=4 units of Novolog, 251-300=6 units of Novolog, 301-350=8 units of Novolog, 351-400=10 units of Novolog, and 401-450=12 units of Novolog.</p> <p>A review of the March MAR (medication administration record) indicated the following Accuchecks: 3/3/13 at 6:00 a.m.=151 3/3/13 at 11:00 a.m.=165 3/9/13 at 11:00 a.m.=154 3/10/13 at 4:00 p.m.=182 3/13/13 at 11:00 a.m.=188 3/13/13 at 4:00 p.m.=153.</p> <p>A review of the March MAR indicated the following administration of Novolog: 3/3/13 (no time indicated)=only 2 units of Novolog administered, was documented that day, 3/9/13=no documentation that Novolog administered, 3/10/13=no documentation that Novolog administered, 3/13/13 (no time indicated)= only 2 units of Novolog administered, was documented that day.</p> <p>2. The clinical record for Resident #37</p>		<p>new system for documenting sliding scale insulins. Inservices were held April 1-3, 2013.4. The Director of Nursing or Designee will monitor sliding scale insulin administration documentation twice weekly for one month then weekly for 3 months. Results will be reported to the Quality Assessment and Assessment Committee monthly for 3 months and then quarterly through March 31, 2014, with a subsequent plan developed and implemented as necessary.Date of completion: April 15, 2013</p>				

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	<p>was reviewed on 3/18/13 at 11:00 a.m. The diagnoses for Resident #37 included, but were not limited to: diabetes mellitus and morbid obesity.</p> <p>A recapitulation of the March Physician's Orders indicated Resident #37 was to receive Accuchecks twice a day. The Physician's Orders also indicated Novolog was to be given on a sliding scale. The Novolog sliding scale was 151-200=2 units of Novolog, 201-250=4 units of Novolog, 251-300=6 units of Novolog, 301-350=8 units of Novolog, 351-400=10 units of Novolog, and over 400, call MD (Medical Doctor).</p> <p>A review of the March MAR (Medication Administration Record) indicated the following Accuchecks: 3/2/13 at 6:00 a.m.=160 3/5/13 at 6:00 a.m.=178 3/5/13 at 8:00 p.m.=230 3/6/13 at 6:00 a.m.=161 3/6/13 at 8:00 p.m.=223 3/9/13 at 6:00 a.m.=160 3/9/13 at 8:00 p.m.=193.</p> <p>A review of the March MAR indicated the following administration of Novolog: 3/2/13=no documentation of Novolog administered that day, 3/5/13=no documentation of Novolog</p>				

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NAME OF PROVIDER OR SUPPLIER  WALDRON HEALTH AND REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 505 N MAIN ST WALDRON, IN 46182		
(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>administered that day, 3/6/13 (no time indicated)=only 4 units of Novolog administered, was documented that day, 3/9/13 (no time indicated)=only 2 units of Novolog administered, was documented that day.</p> <p>During an interview with LPN #3, on 3/19/13 at 1:55 p.m., LPN #3 indicated when Novolog was administered, it should have been documented on the MAR. She also indicated when she looked at the above MARs, she was unable to determine if the medication was administered.</p> <p>On 3/20/13 at 1:15 p.m., the DoN (Director of Nursing), indicated she was unable to locate any documentation that Novolog was given as ordered, for Resident #43 and #37 on the above days, but she was confident that the medication was given, after speaking with the staff involved. She also indicated, the facility probably needed to change the way documentation was done, because it seemed a bit cumbersome.</p> <p>3.1-50(a)(1)</p>				