

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155511	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/22/2014
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NAME OF PROVIDER OR SUPPLIER TERRE HAUTE NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 830 S 6TH ST TERRE HAUTE, IN 47807
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: April 14-17, 21-22, 2014</p> <p>Facility Number: 000446 Provider Number: 155511 AIM Number: 100288720</p> <p>Survey Team: Laura Brashear, RN, TC Mary Weyls, RN April 15-17, 21-22, 2014 Lora Brettnacher, RN</p> <p>Census bed type: SNF/NF: 35 Total: 35</p> <p>Census payor type: Medicare: 7 Medicaid: 25 Other: 3 Total: 35</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.</p>	F000000	<p>02/25/2013 Indiana State Department of Health Division of Long Term Care 2 North Meridian Section 4B Indianapolis, Indiana 46204-3006 Attn: Kim Rhoades, Director, Division of Long Term Care RE: Survey ID 3S7911 April 22, 2014 Annual Recertification Survey Dear Ms. Rhoades, On April 22, 2014, a survey team from the Indiana State Department of Health completed a Recertification Survey at Terre Haute Nursing and Rehabilitation Center. Enclosed please find the Statement of Deficiencies with the facility Plan of Correction for these alleged deficiencies. Please consider this letter and Plan of Correction to be the facility's credible allegation of compliance. This letter is our request for a desk review awarding the facility paper compliance as means to verify that the facility has achieved substantial compliance with the applicable requirement as of the date set forth in the Plan of Correction of May 22, 2014. Please feel free to contact me with any further questions at (812) 232-7102. Respectfully Submitted, Cathy J. Cox-Parker, B.A., HFA Health Facility Administrator</p>	
F000157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)			

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>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 record review and interview, the facility failed to notify a physician of abnormal blood sugar results for 1 of 1 resident reviewed with sliding scale insulin orders which included blood sugar parameter call orders (Resident #34).</p> <p>Findings include:</p>	F000157	By submitting the enclosed material we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility	05/22/2014

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	<p>Resident #34's record was reviewed on 4/21/14 at 11:59 A.M., Resident #34 had diagnoses which included, but were not limited to, dementia and insulin dependent diabetes.</p> <p>An untimed physician ' s order, dated 1/10/14, indicated Resident #34 was to be administered Humalog (insulin) 15 units every day before breakfast, lunch, and dinner. The order indicated her blood sugar levels were to be checked before each meal and at bedtime and the insulin was to be withheld if her blood sugar was below 100. The order further indicated the physician was to be notified if her blood sugar was below 70 or greater than 400.</p> <p>A document titled " Diabetic Monitoring Flow Sheet, " dated March 2014, was reviewed. The records indicated on March 5, 2014, prior to lunch Resident #34 ' s blood sugar was 46 and before dinner it was 428. On March 23, 2014, prior to lunch, Resident #25 ' s blood sugar was 42. The record lacked documentation which indicated the physician was notified as ordered when the Resident #34 ' s blood sugars were below 70 or above 400.</p> <p>A care plan, revised on 4/4/14, indicated Resident #34 was at risk for complications associated with high and/or low blood sugar due to her diagnosis of insulin dependent diabetes. A goal indicated Resident #34 would remain free of complications related to high or low blood sugars. Interventions to meet this goal indicated: 1) Resident #34 ' s blood sugar would be within acceptable parameters according to the physician. 2) The physician would be notified of blood</p>		<p>requests that the plan of correction be considered our allegation of compliance effective May 22, 2014 to the annual licensure survey conducted on April 14, 2014 through April 22, 2014. We respectfully request a paper review. We will provide you with any additional information to confirm compliance per your request. F157 It is the practice of Terre Haute Nursing and Rehabilitation to assure that the physician/family is notified properly when there is a change of condition. The correction action taken for those residents found to be affected by the deficient practice include: Resident #34 physician has been notified of any recent abnormal blood sugars Other residents that have the potential to be affected have been identified by: All diabetic residents have been reviewed to assure that the physician has been notified if the resident's blood sugar is outside of the ordered parameter. No additional residents were identified. The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include: An in-service has been conducted with all nurses related to physician notification specifically related to blood sugars that fall outside of the ordered parameters. The IDT</p>				

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F000164 SS=D	<p>sugar levels less than 70 or greater than 400.</p> <p>During an interview on 4/22/14 at 10:36 A.M., Registered Nurse (RN) #1 and the Director of Nursing (DON) was asked to provide documentation which indicated a physician was notified of Resident #34's abnormal blood sugars on March 5 & 23, 2014.</p> <p>During an interview on 4/22/14 at 11:28 A.M. and at 2:00 P.M., the DON indicated she was not able to provide documentation which indicated a physician was notified of Resident #34's abnormal blood sugars on March 5 and 23, 2014.</p> <p>A policy dated 5/2013, titled "Change in a Resident's Condition or Status" and identified as current by the DON on 4/22/2014 at 11:40 A.M., indicated, "Our facility shall promptly notify the resident, his or her Attending Physician, and... changes in the resident's medical/mental condition and/or status.... Policy Interpretation and Implementation. 1. The Nurse Supervisor/Charge Nurse will notify the resident's Attending Physician or On-Call Physician when there has been...Abnormal lab results that require physician intervention...."</p> <p>3.1-5(a)(2) 483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.</p> <p>Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but</p>		<p>team will be randomly reviewing resident blood sugars as part of the QA process to assure that the physician was notified properly.</p> <p>The corrective action taken to monitor performance to assure compliance through quality assurance is: A Performance Improvement Tool has been initiated that randomly observes 5 residents that receive blood sugar testing to assure that the physician has been notified appropriately. The Director of Nursing, or designee, will complete this tool weekly x3, monthly x3, and quarterly x3. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations for new interventions or training as needed based on the outcome of the PI tool. The date the systemic changes will be completed: May 22, 2014</p>				

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	<p>this does not require the facility to provide a private room for each resident.</p> <p>Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.</p> <p>The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.</p> <p>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.</p> <p>Based on observation, record review and interview, the facility failed to ensure privacy during care for 1 of 3 residents observed receiving incontinence care and/or dressing changes (Resident #23).</p> <p>Findings include:</p> <p>1. On 4/21/14 at 10:45 a.m., RCAs [restorative certified aide] #3 and 6 transferred resident #23 from a wheelchair to the bed. RCA #3 pulled the privacy curtains prior to providing incontinence care. A large gap was noted at the end of the bed between the two privacy curtains and a gap at the head of the resident's bed. The resident's roommate was in the room. RCA #3 removed the resident's slacks, then removed the resident's brief. The resident was left</p>	F000164	<p>F164 It is the practice of Terre Haute Nursing and Rehab to assure that residents receive personal care in a manner that ensures their privacy. The correction action taken for those residents found to be affected by the deficient practice include: Resident #23 is now receiving all personal care in a manner that ensures privacy. Other residents that have the potential to be affected have been identified by: Potentially all residents could be affected. Please see below for measures implemented to prevent reoccurrence. The measures or systematic changes that have been put into place to ensure that the deficient practice does</p>	05/22/2014

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F000242 SS=D	<p>uncovered from the waist down while the RCA placed soap on the washcloth, rinsed the washcloth, and during repositioning of the resident.</p> <p>On 4/16/14 at 2 p.m., Resident #23's roommate was observed to independently ambulate.</p> <p>During interview of Resident #23 on 4/16/14 at 10 a.m., the resident indicated a concern with privacy and indicated staff didn't always shut the privacy curtains during care. Resident #23 stated, "some do and some don't."</p> <p>During review of the resident's clinical record on 4/15/14 at 1:15 p.m., a plan of care was noted with a problem of "Cognitive Loss" with an approach of, "Promote dignity. Converse with resident and ensure privacy while providing care."</p> <p>During review of an undated facility policy, titled "Activities of Daily Living-Perineal Care," received on 4/22/14 at 9:10 a.m., documentation indicated "Raise the gown or lower the pajamas. Avoid unnecessary exposure of the resident's body."</p> <p>3.1-(p)(4)</p> <p>483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices</p>		<p>not recur include: Reinforcement of the facility policy related to providing privacy during the provision of care has occurred. The nursing staff has been in-serviced related to assuring that privacy is provided during all aspects of care provide. Please see below for means of monitoring through observation to assure that the policy is followed in accordance with the regulation. The corrective action taken to monitor performance to assure compliance through quality assurance is: A Performance Improvement Tool has been initiated that randomly reviews 5 residents during the provision of care to assure that appropriate privacy was provided. The Director of Nursing, or designee, will complete this tool weekly x3, monthly x3, and quarterly x3. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations as needed based on the outcomes of the tools. The date the systemic changes will be completed: May 22, 2014</p>	

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	<p>about aspects of his or her life in the facility that are significant to the resident.</p> <p>Based on observation, interview, and record review the facility failed to honor residents' choices regarding times for going to bed for 2 of 9 residents who met the criteria for choices (Residents #39 and #22).</p> <p>Findings include:</p> <p>1. On 4/21/14 at 9:40 am, Resident #39 was interviewed. The resident was in a wheelchair. During the interview, the resident indicated he had been up since 7:30 a.m. and wanted to lay down in bed. The resident indicated staff was aware he wanted to go back to bed after breakfast. The resident indicated it was a frequent occurrence of not being returned to bed in a timely manner.</p> <p>On 4/21/14 at 11:30 a.m., the resident remained in the wheelchair and indicated he had been waiting five hours to lay down. (The resident earlier had indicated he had gotten up at 7:30 am.)</p> <p>The resident was interviewed on 4/16/14 at 11:11 am, and indicated at that time he had to wait at times 5 hours for assistance to bed. During the interview the resident indicated at times it made his bottom hurt.</p> <p>The resident's clinical record was reviewed on 4/21/14 at 1:30 p.m. The initial MDS (Minimum Data Set) assessment dated 1/20/14, coded the resident with moderate cognitive impairment. The assessment indicated the resident required total assistance of two for transfers and was wheelchair dependent. The assessment of preferences indicated it was somewhat</p>	F000242	<p>F242 It is the practice of this facility to assure that residents are treated in a dignified manner including honoring of choices. <i>The correction action taken for those residents found to be affected by the deficient practice include:</i> Resident #39 and #32 are having their choices honored to lay back down after breakfast in a reasonable time frame. <i>Other residents that have the potential to be affected have been identified by:</i> All residents are receiving services in accordance with their choices. Please see below for measures implemented to prevent reoccurrence. <i>The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:</i> Reinforcement of the facility policy related assuring that residents receive services in accordance with their choices. The nursing staff has been in-serviced related to assuring that resident's choices are honored as part of services provided. The in-service will specifically address laying residents down upon their request. Please see below for means of monitoring through observation to assure that the policy is followed in accordance with the regulation. <i>The corrective action taken to</i></p>	05/22/2014

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F000282 SS=D	<p>important for the resident to determine when he wanted to go to bed.</p> <p>2. On 4/21/14 at 9:30 a.m. Resident #22 was in a wheelchair in her room. The resident indicated she had been up since breakfast time. At 11:05 am the resident was still observed in the wheelchair. The resident indicated she has to wait for assistance back to bed for extended times frequently.</p> <p>On 4/21/14 at 11:30 a.m., the ADON (Assistant Director of Nursing) was questioned as to why Resident #39 had not been assisted back to bed. The ADON indicated they had a lot of residents who required use of the lift, and the facility only had one sling lift and had not been able to get to the resident. The ADON indicated staff were aware of the residents wanting to be transferred back to bed and had to wait.</p> <p>On 4/22/14 at 9:10 am, the DON provided a list of eight residents who required use of the lift.</p> <p>3.1-(u)(1) 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN 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 observation, interview, and record review, the facility failed to provide services by a qualified person in that a volunteer attempted to move a resident who was upset for 1 of 1 random observation (Resident #42) and failed to follow physician's orders for monitoring/managing blood sugars as</p>	F000282	<p>monitor performance to assure compliance through quality assurance is: A Performance Improvement Tool has been initiated that randomly observes 5 residents for honoring of residents' wishes and choices. This tool will specifically observe for residents that have requests to assure that they are honored. The Director of Nursing, or designee, will complete this tool weekly x3, monthly x3, then quarterly x3. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations as needed based on the outcomes of the tools. The date the systemic changes will be completed: May 22, 2014</p> <p>F282 It is the practice of this facility to assure that services are provided in accordance with the plan of care. The correction action taken for those residents found to be affected by the deficient practice include: Resident #42</p>	05/22/2014			

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	<p>ordered by the physician for 1 of 5 residents who met the criteria for unnecessary medications. (Resident #34).</p> <p>Findings include:</p> <p>1. On 4/14/14 at 12:15 p.m., Resident #42 was observed in a wheelchair at the back of the dining room. Several residents and staff were in the area. A person, later identified by the Administrator as a volunteer, was observed attempting to transfer the resident in the wheelchair from one table to another. The resident became extremely upset, placed feet on the wall and pushed back which resulted in the chair and resident being flipped onto the floor and hitting his head on the floor.</p> <p>The resident's clinical record was reviewed on 4/22/14 at 3:00 p.m. A quarterly Minimum Data Set (MDS) assessment coded the resident as non ambulatory and independent in wheelchair mobility within the facility. The resident's diagnoses included, but were not limited to Schizophrenia, dementia, and Parkinson's disease.</p> <p>A plan of care with most review date of 1/13/14, indicated the resident had behaviors of hitting staff during ADL (activities of daily living) care and indicated a goal to maintain a non confrontational environment.</p> <p>On 4/14/14 at 12:15 p.m., the Administrator was overheard speaking to the volunteer. The Administrator indicated the volunteer should have walked away when the resident was upset.</p> <p>The Administrator was interviewed 4/14/14 at 12:15 p.m. The Administrator indicated the</p>		<p>receives services by only qualified personnel. Resident #34 is having blood sugars managed as ordered y the physician. Other residents that have the potential to be affected have been identified by: All residents have been reviewed and are receiving services in accordance with the plan of care, the physician's orders, and by qualified personnel. The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include: The nursing staff has been in-serviced related to assuring that residents receive services in accordance with the plan of care, the physician's orders, and by qualified personnel. The in-service included specifics related to addressing blood sugars outside of the ordered parameter and assuring that non-certified or non-licensed staff can't perform care for the residents. The facility has also added to new volunteer training the protocol that they are not to provide care for a resident. The existing volunteers have also received this training. The corrective action taken to monitor performance to assure compliance through quality assurance is: A Performance Improvement Tool has been initiated that randomly reviews 5 diabetic residents related to blood sugar monitoring and blood</p>				

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	<p>volunteer is an AARP volunteer and should have walked away from the resident when he became upset.</p> <p>The Administrator indicated the volunteer came in four hours daily to assist with activities. The Administrator indicated the facility did not train the volunteer. The Activity Director (AD) provided documentation of what training was done by the organization providing volunteer services. The training included, but was not limited to, Resident Rights, Abuse training, and Aspects of Aging, including cognitively impaired residents. The AD indicated the facility did ensure background checks and Mantoux (TB screening) tests were done.</p> <p>2. Resident #34's record was reviewed on 4/21/14 at 11:59 A.M. Resident #34 had diagnoses which included, but were not limited to, dementia and insulin dependent diabetes.</p> <p>An untimed physician's order, dated 1/10/14, indicated Resident #34 was to be administered Humalog (insulin) 15 units every day before breakfast, lunch, and dinner. The order indicated her blood sugar levels were to be checked before each meal and at bedtime and the insulin was to be withheld if her blood sugar was below 100. The order further indicated the physician was to be notified if her blood sugar was below 70 or greater than 400.</p> <p>A document titled "Diabetic Monitoring Flow Sheet," dated March 2014, and the medication administration record (MAR) were</p>		<p>sugars outside of the ordered parameters. The Director of Nursing, or designee, will complete this tool weekly x3, monthly x3, and quarterly x3. Any issues identified will be immediately corrected. Via rounds, the staff will be observing to assure that no unqualified staff provides care to the residents. Any identified issues will be immediately addressed. The Quality Assurance Committee will review the tool at the scheduled meetings with recommendations for additional interventions as needed based on review of the outcomes of the PI tool. The Quality Assurance committee will also review any negative findings identified related to any nonqualified personnel identified to provide care to a resident with additional recommendations if needed. The date the systemic changes will be completed: May 22, 2014</p>	

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	<p>reviewed. The records indicated:</p> <p>1) Blood sugar levels were obtained on March 7, 2014 at breakfast with a result of 106 and March 11, 2014 at lunch with a result of 101. The record lacked documentation insulin was administered as ordered by the physician for either date.</p> <p>2) The record indicated Humalog insulin 15 units was administered to Resident #34 at dinner. The record lacked documentation Resident #34's blood sugars were obtained on March 19, 2014 at dinner prior to the administration of insulin.</p> <p>3) The records lacked documentation Resident #34's blood sugars were obtained on 3/28/14 and 3/30/14 before dinner. The record indicated insulin was not administered.</p> <p>4) On March 5, 2014, prior to lunch Resident #34's blood sugar was 46 and before dinner it was 428. On March 23, 2014, prior to lunch, Resident #25's blood sugar was 42. The record lacked documentation which indicated the physician was notified as ordered when the Resident #34's blood sugars were below 70 or above 400.</p> <p>A care plan, revised on 4/4/14, indicated Resident #34 was at risk for complications associated with high and/or low blood sugar due to her diagnosis of insulin dependent diabetes. A goal indicated Resident #34 would remain free of complications related to high or low blood sugars. Interventions to meet this goal indicated: 1) Resident #34's blood sugar would be within acceptable parameters according to the physician. 2)</p>			

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F000318 SS=D	<p>The physician would be notified of blood sugar levels less than 70 or greater than 400. 3) Insulin would be administered as ordered by the physician. 4) Blood sugars would be monitored as ordered by the physician.</p> <p>During an interview on 4/22/14 at 10:36 A.M., Registered Nurse (RN) #1 and the Director of Nursing (DON) was asked to provide documentation which indicated: 1) Explanation of why Resident #34 was not administered insulin as ordered on March 7 and March 11, 2014. 2) Documentation of Resident #34's blood sugar on March 19, 2014 before dinner prior to the administration of insulin. 3) Documentation Resident #34's blood sugars were obtained on 3/28/14 and 3/30/14 before dinner. 4) Physician notification of abnormal blood sugars on March 5 & 23, 2014.</p> <p>During an interview on 4/22/14 at 11:28 A.M. and at 2:00 P.M., the DON indicated she was not able to provide the information requested.</p> <p>3.1-35(g)(2) 483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.</p> <p>Based on record review and interview, the facility failed to ensure 1 of 3 residents who met the criteria for limited range of motion was provided services to maintain or prevent decline in range of motion (Resident #40).</p>	F000318	F318 It is the practice of Terre Haute Nursing and Rehabilitation to assure that residents identified with limited range of motion receive services to increase range of motion and/or prevent further	05/22/2014

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	<p>Findings include:</p> <p>Resident #40's record was reviewed on 4/21/2014 at 11:20 A.M. Resident #40 had diagnoses which included, but were not limited to, difficult walking, lack of coordination, other late effects of cerebrovascular (stroke) disease, and dementia.</p> <p>An untimed physician's order, dated 3/26/2014, indicated Resident #40's physical therapy services were to be discontinued due to obtaining his maximum potential from physical therapy.</p> <p>A physical therapy evaluation note, dated 3/27/2014, indicated Resident #40 was discontinued from therapy to a restorative nursing program (RNP). This note indicted staff had been trained and a RNP had been put in place for strengthening and bilateral lower extremities range of motion (ROM) to prevent contractures and maintain current strength and ROM.</p> <p>The record lacked documentation Resident #40 had been provided RNP services.</p> <p>During an interview on 4/21/2014 at 1:30 P.M., the Director of Nursing (DON) indicated she did not think Resident #40 was on a restorative nursing program.</p> <p>During an interview on 4/22/14 at 9:35 A.M., the PT (Physical Therapist) manager indicated Resident #40 was supposed to be on a RNP. She indicated he was discontinued from therapy on 3/26/2013. She indicated she filled out a referral for RNP to include bilateral lower extremities ROM</p>		<p>decrease in range of motion. The correction action taken for those residents found to be affected by the deficient practice include: Resident #40 has been reviewed and is now receiving proper restorative services based on therapy's recommendations. Other residents that have the potential to be affected have been identified by: All residents have been reviewed to assure that if there were recommendations from therapy for restorative services that they are receiving the services as recommended. The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include: The Therapy Department will be providing recommendations for restorative services. The recommendations will be given to the MDS Coordinator who is responsible for assuring that a plan is written and restorative services are initiated. The change in the system includes that the therapy will also be providing a copy of the recommendations to the DNS who will review in the morning IDT meeting to assure that the plan is being implemented and restorative services initiated. The MDS Coordinator has been in-serviced related to the importance of restorative services in correlation with the plan of care</p>				

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F000323 SS=E	<p>and seated exercises to maintain his current level of functioning. She indicated the referral was given to the MDS (Minimum Data Assessment) nurse.</p> <p>During an interview on 4/22/2014 at 9:40 A.M., the MDS nurse indicated therapy provided him with the recommendations on 3/23/2014 but he had not developed a plan. He stated he "over looked them."</p> <p>During an interview on 4/22/2014 at 9:45 A.M., the RNA (Restorative Nursing Assistant) indicated she had not provided Resident #40 with ROM services.</p> <p>3.1-42(a)</p> <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, interview, and record review, the facility failed to ensure resident environments were free of accident/hazzard potential for 3 of 3 random observations of unsafe conditions (Resident #25, 42, and Resident #23).</p> <p>Findings include:</p>	F000323	<p>based on the therapist or nursing recommendations being implemented in a timely manner. The corrective action taken to monitor performance to assure compliance through quality assurance is: A Performance Improvement Tool has been initiated that randomly reviews 5 residents for restorative recommendations and proper provision of services. The Director of Nursing, or designee, will complete this tool weekly x3, monthly x3, then quarterly x3. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations as needed. The date the systemic changes will be completed: 5-22-14</p> <p>F323 It is the practice of Terre Haute Healthcare and Rehab to assure that residents' environment is safe and free of hazards. The correction action taken for those residents found to be affected by the deficient practice include: Resident #25 has been reviewed and the side rail has been corrected. Resident #42</p>	05/22/2014			

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	<p>1. During an observation on 4/21/2014 at 10:00 A.M., Resident #25 was observed lying in bed on his back towards the outer edge of his bed with the left side of his body positioned against a quarter side rail. The side rail was observed to not be firmly attached to the bed frame and the gap between the rails/bed frame and mattress edge was excessive.</p> <p>During an observation on 4/21/2014 at 10:04 A.M., RN (Registered Nurse) #1 entered the room and was observed to ask Resident #25 about his pain. She then left the room and stated, " That side rail. I ' m afraid. "</p> <p>During an observation on 4/21/2014 at 10:08 A.M., RN #1 entered Resident #25's room and administered medication to him. Resident #25 remained in the same position against the quarter side rail which was not firmly attached to the bed with an excessive gap between the bed frame and rail. RN #1 left the room and did not address the unsafe side rail.</p> <p>Resident #25's record was reviewed on 4/21/2014 at 12:02 P.M. Resident #25 had diagnoses which included, but were not limited to, rheumatoid arthritis, depression, lower extremity contractures, and chronic severe malnutrition.</p> <p>An unscheduled minimum data set assessment tool (MDS) dated 3/28/14, indicated Resident #25 was cognitively intact with a brief mini mental status (BIMS) score of 13 out of 15 and required extensive assistance of two persons for bed mobility.</p> <p>During an interview on 4/21/2014 at 10:21 A.M., the Assistant Director of Nursing</p>		<p>only receives services by qualified personnel Resident #23 receives 2 person assist when being repositioned in bed. Other residents that have the potential to be affected have been identified by: All residents have been reviewed to assure that the environment is free from hazards and that services are provided by a qualified person and that resident equipment is functioning properly. The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include: The nursing staff has been in-serviced related to providing services to our residents including proper assistance, qualified staff, and proper functioning of equipment in correlation with the written plan of care. Maintenance will be checking resident equipment as part of preventive maintenance to assure proper function. There will be routine monitoring via rounds by nurses and nursing administration to assure that the environment is free from hazards, the plan of care is followed, and that only qualified personnel perform services. The current volunteers as well as future volunteers have/will receive additional training related acceptable activities that they may participate in related to the residents. The corrective action taken to monitor performance</p>				

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	<p>(ADON) indicated Resident #25 ' s side rail did not look safe.</p> <p>During an interview on 4/21/2014 at 10:25 A.M., the Maintenance manager measured the distance from the bed to the side rail and indicated the widest gap measured between the bed and the side rail was 5 inches.</p> <p>During an interview on 4/21/2014 at 10:55 A.M., the Administrator indicated she would have expected her staff to first ensure Resident #25 was safe and then immediately inform her of the concern. The Administrator indicated RN #1 should not have left Resident #25 alone when she noticed the side rail was not safe.</p> <p>During an interview on 4/21/2014 at 10:58 A.M., the Maintenance manager indicated no one had reported the broken side rail to him. He stated, " It was stripped. I tried to tighten it but it came right out again "</p> <p>2. On 4/14/14 at 12:15 p.m., Resident #42 was observed in a wheelchair at the back of the dining room. Several residents and staff were in the area. A person, later identified by the Administrator as a volunteer, was observed attempting to transfer the resident in the wheelchair from one table to another. The resident became extremely upset, placed feet on the wall and pushed back which resulted in the chair and resident being flipped onto the floor and hitting his head on the floor.</p> <p>The resident's clinical record was reviewed on 4/22/14 at 3:00 p.m. A quarterly Minimum Data Set (MDS) assessment coded the resident as non ambulatory and independent</p>		<p>to assure compliance through quality assurance is: A Performance Improvement Tool has been initiated that will be utilized to randomly review 5 residents related to a safe environment. The tool will specifically address proper staff assistance, proper functioning equipment, and staff providing services are operating within their scope of practice. The Director of Nursing, or designee, will complete this tool weekly x3, monthly x3, then quarterly x3. Any areas identified via the audit will be immediately corrected. The Quality Assurance Committee will review the tool at the scheduled meeting following the completion of the tool with recommendations as needed. The date the systemic changes will be completed: May 22, 2014</p>	

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	<p>in wheelchair within the facility. The resident's diagnoses included, but were not limited to Schizophrenia, dementia, and Parkinson's disease.</p> <p>A plan of care, with most recent review date of 1/13/14, addressed the resident had behaviors of hitting staff during ADL (activities of daily living) care and to maintain a non- confrontational environment.</p> <p>On 4/14/14 at 12:15 p.m., the Administrator was overheard speaking to the volunteer. The Administrator indicated the volunteer should have walked away when the resident was upset.</p> <p>3. On 4/21/14 at 10:45 a.m., RCAs [restorative certified aide] #3 and 6 transferred Resident #23 from a wheelchair to the bed. RCA #3 stated to RCA #6, "Don't leave. It takes two people to roll him over in bed. He's hard to roll." During incontinence care, RCA #3, without assistance, rolled the resident two times from the middle of the bed toward the wall, pressing the resident's head and right arm and hand against the wall.</p> <p>A policy and procedure dated 8/2009, titled "BED POSITIONING" was received from the ADON [assistant director of nursing] on 4/22/14 at 9:10 a.m. The "purpose" of the procedure was "To promote resident comfort, safety and dignity..." The documentation indicated, but was not limited to, when repositioning a dependent resident in bed, to use a pull sheet under the resident with a caregiver on each side of the bed.</p>			

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F000332 SS=D	<p>3.1-45(a)(1) 3.1-45(b)(2) 483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater.</p> <p>Based on observation, interview, and record review the facility failed to ensure it was free from medication error rates of 5 percent or greater in that 2 errors in the opportunity for 26 medication administration were observed, resulting in a 7.6 per cent error rate. (Residents #3 and #19)</p> <p>Findings include:</p> <p>1. On 4/21/14 at 11:15 a.m., RN #1 administered medications to Resident #3. The nurse instilled two drops of Tears Naturale Forte eye drops into both of the resident's eyes.</p> <p>Resident #3's clinical record was reviewed on 4/21/14 at 3:05 p.m. A physician's order dated 1/10/14, on the signed April 2014 recapitulation of orders, included, but was not limited to, "Tears Naturale Forte Drop Instill 1 drop in right eye 3 times daily Dx (diagnosis) Dry eyes."</p> <p>2. During medication administration on 4/21/14 at 11:22 a.m., RN #5 administered medication to resident #19. The RN was unable to find the physician's ordered medication "Dipyridamole" [platelet inhibitor].</p> <p>During interview of RN # on 4/21/14 at 1 p.m., the RN indicated he was unable to find</p>	F000332	<p>F332 It is the practice of this facility to assure that each resident receives all medications in accordance with the physician's orders. The correction action taken for those residents found to be affected by the deficient practice include: Resident #3 and #19 has been reviewed and is receiving medications in correlation with the physician's orders. Other residents that have the potential to be affected have been identified by: All residents have been reviewed to assure they are receiving medications in accordance with the physician's orders. The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include: Nurses have been in-serviced related to assuring that medications are administered in accordance with the physician's orders. The in-service included that if a medication is not identified to be on the medication cart that the pharmacy is to be notified immediately so that the medication is delivered. The</p>	05/22/2014			

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F000441 SS=F	<p>the prescribe medication of Dipyridamole for resident #19, and was unable to administer the prescribed noon dose.</p> <p>During review of Resident #'s clinical record on 4/21/14 at 2 p.m., the most recent physician's orders were signed on 3/13/14. An order for "Dipyridamole 50 mg tablet take one tablet 3 times a day Dx HTN [hypertension]" was noted.</p> <p>3.1-25(b)(9)</p> <p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual</p>		<p>corrective action taken to monitor performance to assure compliance through quality assurance is: A Performance Improvement tool has been established that randomly reviews 5 residents during medication administration.. The tool will specifically review accurate following of the physician's orders and availability of medications. The Director of Nursing, or designee, will complete the tool weekly x3, monthly x3, then quarterly x3. Any issues identified will be immediately addressed. The Quality Assurance Committee will review the tool at the scheduled meeting following the completion of the tool with recommendations as needed based on the outcome of the tools. The date the systemic changes will be completed: May 22, 2014</p>	

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	<p>resident; and</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation, record review, and interview, the facility failed to implement contact isolation precautions for 1 of 1 observation of wound care to a resident on contact isolation (Resident #25). The facility failed to ensure sanitary handling of oral medication cups and failed to ensure proper cleaning of a blood glucose monitoring machine. (Resident #23) This deficient practice had the potential to affect all 35 residents of the facility.</p> <p>Findings include:</p> <p>1. During an observation on 4/22/2014 at 10:59 A.M., Registered Nurse (RN) #1 and Assistant Director of Nursing (ADON) were</p>	F000441	F441 It is the practice of this facility to assure that all procedures are conducted in a manner that is in accordance with infection control guidelines. The correction action taken for those residents found to be affected by the deficient practice include: Resident #25 is receiving care in a manner that is within acceptable parameters of infection control Resident #23 is receiving blood glucose testing in a manner that is within acceptable parameters of infection control. Other residents that have the potential to be affected have	05/22/2014

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	<p>observed performing wound care on Resident #25. Resident #25 was positioned on his left side. The ADON held the resident in the side lying position while RN #1 positioned herself on the floor next to the bed to provide wound care. RN #1's shirt sleeves and and scrub top repeatedly came in contact with Resident 40's bed linens when she leaned against the bed to remove old dressings and apply new dressings to a stage four coccyx wound and a stage three buttock wound.</p> <p>During an observation on 4/22/2014 at 12:15 P.M., an covered large brown box lined with a clear bag contained bags of trash. An uncovered white container with the word "isolation" written on it was observed in Resident #25's room and was overflowing with crumpled up linens.</p> <p>Resident #25's record was reviewed on 4/21/2014 at 12:02 P.M. Resident #25 had diagnoses which included, but were not limited to, rheumatoid arthritis, depression, lower extremity contractures, multiple pressure ulcers, chronic severe malnutrition, incontinence of bowel, and Clostridium Difficile,</p> <p>An untimed physician's order, dated 2/21/2014, indicated Resident #25 had orders for a wound culture to an open area on his right knee.</p> <p>A lab result, dated 2/24/2014, indicated Resident #25 tested positive for a moderate amount of Methicillin Resistant Staphylococcus Aureus (MRSA) and Proteus Mirabilis in his knee.</p> <p>A care plan, dated 2/21/2014, indicated</p>		<p>been identified by: All residents could potentially be affected. All residents are receiving services in a manner which promotes acceptable infection control. Please see system changes and means of monitoring below. The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include: An in-service has been conducted for nursing staff related to proper infection control practices. The in-service will address isolation and sanitizing of the glucometer. The facility nursing administration will be randomly observing staff that is providing services to assure that proper infection control protocol is followed in accordance with the facility policy related to both isolation and sanitizing of the glucometer. The corrective action taken to monitor performance to assure compliance through quality assurance is: A Performance Improvement Tool has been initiated that randomly observes 5 residents related to following of proper infection control procedures. The observations will include proper isolation based on the organism identified and proper sanitizing of the glucometer machine. The Director of Nursing, or designee, will complete these tools weekly x3, monthly x3, then quarterly x3. Any issues identified will be</p>				

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	<p>Resident #25 was placed in contact isolation due to MRSA in his knee wound.</p> <p>A lab result, dated 2/24/2014, indicated Resident #25 was positive for clostridium difficile (C-Diff). He was treated with an antibiotic for the C-Diff.</p> <p>A family education record, dated 3/15/14, indicated Resident #25 was informed he would remain in isolation until he consented to wound cultures.</p> <p>The record indicated the knee wound closed on 3/23/2014. The record indicated Resident #25 had a stage 4 pressure sore to his coccyx and a stage 3 pressure sore to his buttock. Neither had been cultured.</p> <p>During an interview on 4/22/1014 at 12:01 P.M. with the Director of Nursing (DON), the Assistant Director of Nursing (ADON) and Hospice Nurse #9 present, Hospice Nurse #9 indicated she did not have knowledge of Resident 25's wounds being cultured or knowledge of an infection. The ADON indicated Resident #25 was in contact isolation for MRSA in his wounds and staff utilized contact isolation when they provided care. The DON indicated the resident had recently been treated for C-Diff. The DON indicated she would have expected RN #1 to wear a gown to protect her clothes during the dressing change.</p> <p>During an interview on 4/22/2014 at 12:10 P.M., Certified Nursing Assistant (CAN) #8 indicated she and another CNA were assigned to Resident #25 and had provided care for him throughout the day. She stated, " No he is not on isolation. I know he use to have C-Diff but no he is not on isolation. "</p>		<p>immediately corrected and additional training will immediately occur. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations for new interventions as needed based on the outcomes of the tools. <i>The date the systemic changes will be completed: May 22, 2014</i></p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155511	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/22/2014
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NAME OF PROVIDER OR SUPPLIER TERRE HAUTE NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 830 S 6TH ST TERRE HAUTE, IN 47807
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	<p>She indicated she "remembered seeing boxes" for isolation in his room.</p> <p>During an interview on 4/22/2014 at 12:12 P.M., Hospice Nurse #9 stated, "No, I was not aware he was on isolation or precautions other than standard."</p> <p>During an interview on 4/22/14 at 2:10 P.M., the DON indicated Resident #25's wound with MRSA was healed and he was not symptomatic with C-Diff but she kept him on contact isolation for precautionary reasons.</p> <p>A policy dated 12/07, identified as current by the administrator on 4/22/2014 at 2:49 P.M., and titled "Isolation/Categories of Transmission/Based Precautions" indicated, "...Contact precautions...addition to standard precautions implement contact precautions for residents known or suspected to be infected or colonized with microorganisms that can be transmitted by direct contact with the resident or indirect contact with environmental surfaces with resident care items in the residents environment...wear a gown for all interactions that may involve contact with the resident or potential contaminated items in the resident's environment...."</p> <p>2. On 4/21/14 at 11:15 a.m., RN #1 was observed to test Resident #23's blood sugar with a Microdot Blood Glucose Monitor. The nurse removed the meter from a case on top of the medication cart, gathered other supplies, put the meter into her uniform pocket, entered the resident's room, washed hands and put on gloves. With the strip inserted in the meter, the nurse swabbed the</p>			

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	<p>resident's finger with an alcohol swab, performed the finger stick, and touched the strip to the blood drop. After the finger stick, the nurse used a paper towel to wipe the blood drop site. The nurse removed the test strip, put the meter back into her uniform pocket, disposed of cleaning supplies and lancet in sharps container, removed gloves and washed hands. The nurse exited the room, laid the meter on top of the medication cart. The nurse took a canister of "microdot BLEACH WIPE," from the bottom drawer of the cart, dispensed a wipe and wiped the front and back of the meter. The nurse placed the meter on a tissue on top of the cart to air dry.</p> <p>The Manufacturer's directions for use of the sanitizer product, provided by the DON on 4/22/14 at 10:00 a.m., included, but were not limited to "Directions for use...Apply towellette and wipe desired surface to be disinfected. Allow treated surfaces to remain thoroughly wet for 5 minutes. Allow surface to air dry..."</p> <p>A facility policy titled "Single Resident Use Blood Glucometers," dated 5/2013, provided by the DON on 4/22/14 at 10:17 am, included, but was not limited to, "1. Place glucometer on top of clean barrier (i.e. Kleenex) 5. Wrap glucometer in disinfectant wipe and place glucometer on clean barrier. 6. Allow glucometer to maintain contact with disinfectant wipe thereby keeping glucometer wet with solution for time prescribed by wipe manufacturer."</p> <p>3. On 4/21/14 at 12:05 p.m. RN #1 was observed during medication pass. The RN was observed to pick up plastic medication cups for oral medication administration stored in an upright stack on top of the</p>			

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	<p>medication cart by placing a finger on the interiors of the cups.</p> <p>During an interview of the DON on 4/22/14 at 10:17 a.m., the DON indicated they should have been stacked tops down and the interior surface of the medication cup should not have been touched.</p> <p>3.1-18(k)(1)</p>			