

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155784	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/07/2012
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NAME OF PROVIDER OR SUPPLIER MICHIANA HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1420 E DOUGLAS RD MISHAWAKA, IN 46545
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F0000	<p>This visit was for the Investigation of Complaints IN00113432, IN00113982, and IN00115637.</p> <p>Complaint IN00113432-Substantiated. Federal/state deficiencies related to the allegation are cited at F157, F224, F226, and F514.</p> <p>Complaint IN00113982-Substantiated. Federal/state deficiencies related to the allegation are cited at F333 and F9999.</p> <p>Complaint IN00115637-Substantiated. Federal/state deficiencies related to the allegations are cited at F157, F333, F514, and F9999.</p> <p>Survey dates: September 5, 6, & 7, 2012</p> <p>Facility number: 012329 Provider number: 155784 AIM number: 201002500</p> <p>Survey team: Janet Adams, RN, TC Janelyn Kulik, RN September 5, 2012</p> <p>Census bed type: SNF: 29</p>	F0000	<p>This Plan of Correction is the center's credible allegation of compliance. Preparation and / or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and / or executed solely because it is required by the provisions of federal and state law. Michiana Health and Rehabilitation Center respectfully request a desk review of the following survey.</p>	

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>SNF/NF: 54 Total: 83</p> <p>Census payor type: Medicare: 29 Medicaid: 31 Other: 23 Total: 83</p> <p>Sample: 13</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on September 10, 2012 by Bev Faulkner, RN</p>			

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F0157 SS=D	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on record review and interview, the facility failed to contact the attending Physician for medication orders upon admission to the facility and failed to notify the Physician and family member</p>	F0157	F157 It is the practice of this facility that the resident, resident's physician and resident's family or legal representative will be informed when there is an accident involving the resident	09/30/2012	

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	<p>of a resident sustaining and injury for 1 of 1 residents reviewed for injuries and 2 of 3 residents reviewed for admission orders in the sample of 13. (Residents #B, #G, and #M)</p> <p>Findings include:</p> <p>1. The record for Resident #B was reviewed on 9/5/12 at 1:45 p.m. The resident's diagnoses included, but were not limited to, malignant brain neoplasm and convulsions. The 7/17/12 Minimum Data Set (MDS) admission assessment indicated the resident required extensive assistance of two staff members for bed mobility, transfers, dressing, personal hygiene, and toileting.</p> <p>Review of a 7/28/12 Resident Incident report indicated an incident occurred at 1:00 a.m. The report indicated the resident was left on the bedpan and staff observed a bruise on the resident's left buttock measuring 0.2 cm (centimeters) "thick" and 15.2 cm in length and another bruise to the right buttock measuring 0.2 cm "thick" and 15.4 cm in length was also noted. Both of the above areas were noted to be reddish purple in color. The report described the pain as "hurts little bit." The report indicated the Physician was notified of the incident on 7/28/12 at 2:49 p.m., and the resident's family was</p>		<p>which results nonjury and has the potential for requiring physician intervention: a significant change in residents physical, mental, or psychosocial status: a need to alter treatment significantly; or a decision to transfer or discharge the resident from the facility.</p> <p>Corrective Action: Resident B's chart was reviewed to ensure family and physician notification was completed. Review of current in house residents who have had an accident or incident in the past 30 days to be completed to ensure families and physicians were notified timely.How Others Identified: Review of current in house residents who have had an accident or incident in the past 30 days to be completed to ensure families and physicians were notified timely. Residents residing in the facility will be addressed by following policy and procedure and re-education and/or disciplinary action of employees.Preventative Measures: The nurse is to call the on-call nurse with each A & I report. The on-call nurse will remind the nurse to notify the family and physician. The Unit Manager, ETD, DON, or designee will check the A & I reports to ensure the nurse filling out the report had notified the family and physician. Expectation of notice to the nurses to contact the on call nurse with all A & I was done</p>				

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	<p>notified of the incident on 7/28/12 at 2:54 p.m.</p> <p>The 7/28/12 Nurses' Notes were reviewed There was no documentation of the above occurrence in the Nurses' Notes. There was no documentation of family and or Physician notification of the incident.</p> <p>When interviewed on 9/6/12 at 10:35 a.m., the Director of Nursing indicated the Physician and family notification of the above incident was not completed in a timely manner.</p> <p>The facility policy titled "Notification of Resident Change in Condition" was reviewed on 9/5/12 at 9:42 a.m. The policy was received from the Administrator and identified as current. There was a revised date of July 2011 on the policy. The policy indicated staff were to "notify the Physician and the family or legal representative at the earliest possible time , during waking hours, if there is an non-critical change in condition." The policy also indicated staff were to document the notification times in the Nurses' Notes along with the name of the persons they spoke to.</p> <p>2. The record for Resident #M was reviewed on 9/6/12 at 9:00 a.m. The resident was admitted to the facility on</p>		<p>during re-education in-services on 9/24/2012 and 9/25/2012. In addition, a message was placed in our care tracker system as a notification that is read by all nurses when they access care tracker.</p> <p>Monitoring: The Unit Manager, ETD, DON or designee will check the A & I reports each morning before clinical review to ensure the family and physician had been notified. The monitoring log will be check daily for 2 weeks, 3 times a week for 2 weeks, weekly for 8 weeks, then monthly for 3 months. Trends will be reviewed in QA monthly times 3 months and quarterly thereafter to determine further education and/or monitoring needs. Tool will be turned into and monitored by the DON for completion. Identified non-compliance will result in one to one re-education up to and including termination. Any identified trends will be forwarded to the administrator for review and presented to QA to determine further educational needs. Systems Changes: Completed by 9/30/2012 F157 It is the practice of this facility that the resident, resident's physician and resident's family or legal representative will be informed when there is an accident involving the resident which results injnjury and has the potential for requiring physician intervention: a significant change in residents physical, mental, or</p>				

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	<p>8/22/12. The resident's diagnoses included, but were not limited to, coronary artery disease, high blood pressure, depression, and chronic airway obstruction. Several pages of copies of transfer Orders/Instructions from the hospital were in the resident's record. The records did not list the resident's facility attending Physician as the hospital Physician. The medications ordered on the hospital form were written onto a facility Physician Order Sheet on 8/22/12. Review of the 8/22/12 Nurses' Notes indicated there was no documentation of the attending Physician being notified of resident's admission or the transfers orders.</p> <p>When interviewed on 9/6/12 at 3:35 p.m., the Director of Nursing indicated it is facility protocol to accept the electronically signed orders from the hospital doctors when the residents are admitted to the facility and then the attending physician at the facility will see the resident the next day and review the orders.</p> <p>3. The closed record for Resident #G was reviewed on 9/5/12 at 12:25 p.m. The resident's diagnoses included, but were not limited to, congestive heart failure, chronic obstructive pulmonary disease, malignant neoplasm of the prostate,</p>		<p>psychosocial status: a need to alter treatment significantly: or a decision to transfer or discharge the resident from the facility. Facility failed to contact attending physician for medication orders upon admission to facility. Corrective Action: Resident G and M's chart was reviewed to ensure all orders were verified by the physician. Review of current in house residents who have been admitted within the last 2 weeks to ensure all physicians orders were verified. How Others Identified: . Review of current in house residents who have been admitted within the last 2 weeks to ensure all physicians orders were verified. Residents residing in the facility will be addressed by following policy and procedure and re-education and/or disciplinary action of employees. Preventative Measures: With each new admission or re-admission, the 1st admitting nurse will follow the "to do" list. The first step is to verify all admit orders with the attending physician and document in the nurse's notes that this was completed. The Unit Manager, ETD, DON, or designee will check to ensure all admit orders were verified by the attending physician. Monitoring: The Unit Manager, ETD, DON, or designee will check each new admission, prior to daily clinical review, to ensure</p>				

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	<p>diabetes, and atrial fibrillation (an irregular heart beat). The resident was admitted to the facility on 8/23/12 and was discharged to the hospital on 8/26/12. The resident was admitted from a VA (Veteran's Administration) healthcare facility.</p> <p>The Nursing Comprehensive Admission Data Collection and Assessment indicated the resident was admitted to the facility on 8/23/12 at 5:00 p.m. Copies of the electronically signed Physician medication orders included for the resident to receive Novolin 70/30 insulin of 50 units under the skin before breakfast and 35 units before supper. The initial's D/C (discontinue) were hand written in next to these typed medications.</p> <p>The initial Physician orders were written for 70/30 Insulin 35 units at 6:00 p.m. and 50 units at 8:00 a.m. The 6:00 p.m. dose of the 70/30 Insulin was not signed out as given on 8/23/12. A new page of Physician orders were hand written and dated 8/24/12 onto a Medication Administration sheet. There were no orders for the 70/30 insulin. There was an order for Human regular insulin to be administered subcutaneous via a sliding scale. This order was dated 8/24/12. The Medication Administration Record sheet indicated the resident received 8 units of</p>		<p>all orders were verified and noted in the nurses note. The DON or designee will check all new admits each day during daily clinical review to ensure all orders were verified and nurses noted. The monitoring log will be check daily for 2 weeks, 3 times a week for 2 weeks, weekly for 8 weeks, then monthly for 3 months. Trends will be reviewed in QA monthly times 3 months and quarterly thereafter to determine further education and/or monitoring needs. Tool will be turned into and monitored by the DON for completion. Identified non-compliance will result in one to one re-education up to and including termination. Any identified trends will be forwarded to the administrator for review and presented to QA to determine further educational needs,. Systems Changes: Completed by 9/30/2012</p>				

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	<p>Human regular insulin at 8:00 a.m., for a blood sugar level of 276 on 8/24/12.</p> <p>When interviewed on 9/6/12 at 3:35 p.m., the Director of Nursing indicated the resident was admitted from a VA hospital. The Director of Nursing indicated it is facility protocol to accept the electronically signed orders from the hospital doctors when the residents are admitted to the facility and then the attending physician at the facility will see the resident the next day and review the orders. The Director of Nursing indicated the nursing staff had been attempting to call the Physician from the VA hospital to clarify the high doses of the 70/30 insulin but were unable to reach the Physician and they did not attempt to call the listed attending Physician. The Director of Nursing indicated the attending Physician was at the facility at around 8:00 a.m., on the next day and clarified the insulin orders and the resident received the insulin coverage as ordered starting at 8:00 a.m.</p> <p>The facility policy titled "Admission Orders" was received from the Director of Nursing on 9/6/12 at 5:10 p.m. The policy had a revised date of January 2012. The policy indicated Admission orders were to obtained/approved through the attending Physician as soon as possible</p>				

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	<p>following or prior to the resident's admission to the facility. The policy also indicated the Medical Director was to be contacted if the attending Physician or their alternate could not be reached. If a resident was admitted from a hospital the staff were to review the transfer orders and "contact the attending Physician as soon as possible upon admission (if the attending Physician is not the transferring Physician) to confirm orders." Staff were also to review the transfer orders with the attending Physician and obtain approval and transcribe the approved transfer orders and any further orders onto a Physician's Order Sheet.</p> <p>This Federal tag relates to Complaints IN00113432 and IN00115637.</p> <p>3.1-5(a)(1) 3.1-5(a)(3)</p>			

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F0224 SS=D	<p>483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATE</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>Based on record review and interview, the facility failed to ensure residents remained free of neglect related to a dependent resident being left on a bed pan for an extended period of time, which resulted in an injury for 1 of 3 residents reviewed who were identified as having had used bedpan at times in the sample of 13.</p> <p>(Resident #B) (CNA #1 and CNA#2)</p> <p>Findings include:</p> <p>The record for Resident #B was reviewed on 9/5/12 at 1:45 p.m. The resident's diagnoses included, but were not limited to, malignant brain neoplasm and convulsions. The 7/17/12 Minimum Data Set (MDS) admission assessment indicated the resident required extensive assistance of two staff members for bed mobility, transfers, dressing, personal hygiene, and toileting.</p> <p>Review of a 7/28/12 Resident Incident report indicated an incident occurred at</p>	F0224	<p>F224: It is the practice of this facility to implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of residents property. The facility failed to ensure residents remained free of neglect related to a dependent resident being left on a bed pan for an extended period of time, which resulted in an injury.</p> <p>Corrective Action: A full skin assessment was completed on resident B to ensure no lasting physical effects from the bad pan placement. Review of current in house residents who use a bed pan to ensure no physical harm occurred as a result of inappropriate bed pan use.</p> <p>Preventative Measures: All staff to be re-educated on bed pan use. Also, re-educate the importance of doing rounds at change of shift to ensure no resident is left on the bed pan. The nurse is to ensure the oncoming CNA's are doing rounds with the off going CNA's.</p> <p>Monitoring: The CNA's, coming and going, are to sign the log that indicated rounds have been</p>	09/30/2012			

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	<p>1:00 a.m. The report indicated the resident was left on the bedpan and staff observed a bruise on the resident's left buttock measuring 0.2 cm (centimeters) "thick" and 15.2 cm in length and a second bruise to the right buttock measuring 0.2 cm "thick" and 15.4 cm in length was also noted. Both of the above areas were noted to be reddish purple in color. The report described the pain as "hurts little bit."</p> <p>Review of the Unusual Occurrence Report Form indicated the incident occurred on 7/28/12 at 1:00 a.m. The form indicated the resident had been on the bed pan for an extended period of time and was found on the bed pan during rounds. The facility investigation indicated the resident was put on the bed pan at some time on the evening shift. The staff were interviewed. The CNA assigned to care for the resident on the evening shift (7/27/12) was interviewed and indicated she had put the resident on and off the bed pan that evening at approximately 7:45 p.m. and took the resident off after she had finished using the bed pan. The Nurse assigned to care for the resident on the evening shift (7/27/12) was interviewed and indicated she had provided medications and treatments to the resident approximately between 8:00 p.m. and 8:30 p.m. and the</p>		<p>completed with all residents before they leave the residents they are responsible for. The nurse will also initial that the CNA's have completed rounds. The Unit Manager, ETD, DON, or designee will monitor this log before daily clinical review to ensure completeness. This log will be monitored for accuracy daily for 2 weeks, 3 times a week for 2 weeks, weekly for 8 weeks, then monthly for 3 months and monthly for 3 months. Trends will be reviewed in QA monthly times 3 months and quarterly thereafter to determine further education and/or monitoring needs. Tool will be turned into and monitored by the DON for completion. Identified non-compliance will result in one to one re-education up to and including termination. Any identified trends will be forwarded to the administrator for review and presented to QA to determine further educational needs,.</p> <p>Systems Changes: Completed by 9/30/2012</p>				

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	<p>resident had no issues or concerns. The report indicated the resident was found on the bed pan during the first rounds on the night shift and the bed pan had been used.</p> <p>When interviewed on 9/5/12 at 2:25 p.m., the Director of Nursing indicated Resident #B was observed on the bed pan on 7/28/12 at 1:00 a.m., by the night shift CNA. The Director of Nursing indicated the incident was reported to the Indiana State Department of Health. The Director of Nursing indicated an investigation into the incident was initiated. The Director of Nursing indicated the Nurses and CNA's on the evening and night shifts were interviewed. Both Nurses did not note the resident on the bedpan. The evening shift CNA (CNA #2) reported she had put the resident on and off the bed pan earlier but did not leave the resident on the bed pan. The night shift CNA (CNA #1) reported she first checked and found the resident on the bed pan at 1:00 a.m. on her rounds. The Director of Nursing indicated no staff members working on the unit on the above two shifts indicated they had placed the resident on the bed pan.</p> <p>When interviewed on 9/5/12 at 5:10 p.m., the Director of Nursing indicated the CNA at the end of each shift is to make rounds room to room on each resident</p>			

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	<p>with the CNA on the oncoming shift. The residents are supposed to be checked by the two CNA's and they are supposed to provide care that is needed at that time. The Director of Nursing indicated the two CNA's working did not do the rounds to check on Resident #B on the date Resident #B was found on the bed pan. The Director of Nursing also indicated there is not a policy on the staff making rounds together at the change of each shift though every CNA is aware of the protocol. The Director of Nursing indicated she did not do audits or interventions after the incident with Resident #B to ensure the change of shift rounds are being done.</p> <p>The facility policy for Prevention Reporting: Resident Mistreatment, Neglect, Abuse, Including Injuries of Unknown Source, and Misappropriation of Resident Property was received from the facility Administrator on 9/7/12. The policy had a revised date of April 2012. The policy indicated the facility prohibits the mistreatment, neglect, and abuse of residents and misappropriation of resident property by anyone including staff, family, and friends. The policy also defined neglect as the "failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155784	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/07/2012
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	<p>This Federal tag relates to Complaint IN00113432.</p> <p>3.1-27(a)(3)</p>			

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F0226 SS=D	<p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>Based on record review and interview, the facility failed to follow their policy related to the prevention of neglect for 1 of 1 allegation of neglect in the sample of 13. (Resident #B)</p> <p>Findings include:</p> <p>The record for Resident #B was reviewed on 9/5/12 at 1:45 p.m. The resident's diagnoses included, but were not limited to, malignant brain neoplasm and convulsions. The 7/17/12 Minimum Data Set (MDS) admission assessment indicated the resident required extensive assistance of two staff members for bed mobility, transfers, dressing, personal hygiene, and toileting.</p> <p>Review of a 7/28/12 Resident Incident report indicated an incident occurred at 1:00 a.m. The report indicated the resident was left on the bedpan and staff observed a bruise on the resident's left buttock measuring 0.2 cm (centimeters)</p>	F0226	<p>F226: It is the practice of this facility to develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. The facility failed to follow their policy related to the prevention of neglect.</p> <p>Corrective Action: A full skin assessment was completed on resident B to ensure no lasting physical effects from the bad pan placement. Review of current in house residents who use a bed pan to ensure no physical harm occurred as a result of inappropriate bed pan use.</p> <p>Preventative Measures: All staff to be re-educated on bed pan use. Also, re-educate the importance of doing rounds at change of shift to ensure no resident is left on the bed pan. The nurse is to ensure the oncoming CNA's are doing rounds with the off going CNA's.</p> <p>Monitoring: The CNA's, coming and going, are to sign the log that indicated rounds have been completed with all residents before they leave the residents they are responsible for. The nurse will also initial that the</p>	09/30/2012			

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	<p>"thick" and 15.2 cm in length and a second bruise to the right buttock measuring 0.2 cm "thick" and 15.4 cm in length was also noted. Both of the above areas were noted to be reddish purple in color. The report described the pain as "hurts little bit."</p> <p>Review of the Unusual Occurrence Report Form indicated the incident occurred on 7/28/12 at 1:00 a.m. The form indicated the resident had been on the bed pan for an extended period of time and was found on the bed pan during rounds. The facility investigation indicated the resident was put on the bed pan at some time on the evening shift. The staff were interviewed. The CNA assigned to care for the resident on the evening shift (7/27/12) was interviewed and indicated she had put the resident on and off the bed pan that evening at approximately 7:45 p.m., and took the resident off after she had finished using the bed pan. The Nurse assigned to care for the resident on the evening shift (7/27/12) was interviewed and indicated she had provided medications and treatments to the resident approximately between 8:00 p.m. and 8:30 p.m., and the resident had no issues or concerns. The report indicated the resident was found on the bed pan during the first rounds on the night shift and the bed pan had been used.</p>		<p>CNA's have completed rounds. The Unit Manager, ETD, DON, or designee will monitor this log before daily clinical review to ensure completeness. This log will be monitored for accuracy daily for 2 weeks, 3 times a week for 2 weeks, weekly for 8 weeks, then monthly for 3 months and monthly for 3 months. Trends will be reviewed in QA monthly times 3 months and quarterly thereafter to determine further education and/or monitoring needs. Tool will be turned into and monitored by the DON for completion.</p> <p>Identified non-compliance will result in one to one re-education up to and including termination. Any identified trends will be forwarded to the administrator for review and presented to QA to determine further educational needs.</p> <p>Systems Changes: Completed by 9/30/2012</p>				

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	<p>The facility policy for Prevention Reporting: Resident Mistreatment, Neglect, Abuse, Including Injuries of Unknown Source, and Misappropriation of Resident Property was received from the facility Administrator on 9/7/12. The policy had a revised date of April 2012. The policy indicated the facility prohibits the mistreatment, neglect, and abuse of residents and misappropriation of resident property by anyone including staff, family, and friends. The policy also defined neglect as the "failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness. The policy indicated the facility was to ensure implementation of prevention techniques which include, ongoing supervision of residents and staff, the observation of care, observations of signs of burnout in staff, and observation of resident to staff frustration or stress. The facility was also to to identify, corrects and intervene in situations where neglect and abuse could be likely to occur. The policy also indicated measures to implement the above were to include, monitoring secluded areas, sufficient staffing on shifts to meet the resident's needs, and staffing and supervision to identify inappropriate behaviors.</p>			

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	This Federal tag relates to Complaint IN00113432. 3.1-28(a)(1)			

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F0333 SS=D	<p>483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS</p> <p>The facility must ensure that residents are free of any significant medication errors. Based on record review and interview, the facility failed to remain free of significant medication errors related to the administration of IV (intravenous) narcotic pain medications for 1 of 3 residents in the sample of 13 reviewed for the administration of pain medications. (Resident #F)</p> <p>Findings include:</p> <p>The record for Resident #F was reviewed on 9/7/12 at 8:00 a.m. The resident's diagnoses included, but were not limited to, anemia, open chest wound, and thrombosis of the inferior vena cava (clot in an artery).</p> <p>Review of the 8/12 and 9/12 Physician Order Statements indicated there were Physician orders for the Resident to receive Hydromorphone (a narcotic medication given for pain) 2 mg (milligrams/1 ml (milliliter) vial -.15 ml to equal 0.3 mg thru the PICC (peripherally inserted central intravenous catheter) every hour from 6:00 a.m. though 9:00 p.m. There was also an order for the resident to be given Hydromorphone 2 mg/1 ml - .15 ml</p>	F0333	<p>F333: It is the practice of this facility to ensure that residents are free of any significant medication errors. The facility failed to remain free of significant medication errors.</p> <p>Corrective Action: A MAR audit was completed on resident F to ensure no other medication errors had occurred. The nurse with the med error has been given a disciplinary action. Review of current in house residents who have IV push med to ensure to med error related to administration of medication.</p> <p>Preventative Measures: All nurses will be re-educated on proper med administration and documentations. As well as proper reading of the MAR before administering medication.</p> <p>Monitoring: The Unit Manager, ETD, DON, or designee will check the MAR's of all IV push residents, before daily clinical review to ensure all IVP meds were given in compliance with the physicians order. . The Unit Manager, ETD, DON, or designee will monitor this log before daily clinical review to ensure completeness. This log will be monitored for accuracy daily for 2 weeks, 3 times a week for 2 weeks, weekly for 8 weeks, then monthly for 3 months and monthly</p>	09/30/2012			

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	<p>intravenously every 2 hours prn (to be given as needed) from 9:00 p.m. through 6:00 a.m.</p> <p>Review of the 8/12 Medication Administration Record indicated the resident received the scheduled Hydromorphone every hour from 6:00 a.m. through 9:00 p.m. on 8/25/12. The Medication Administration Record also indicated the resident received the prn Hydromorphone at 10:00 p.m. and 11:00 p.m. on 8/25/12. This indicated the resident received the Hydromorphone at 9:00 p.m., 10:00 p.m., and 11:00 p.m.</p> <p>Review of the 9/12 Medication Administration Record indicated the resident received the scheduled Hydromorphone every hour from 6:00 a.m. through 9:00 p.m. on 9/3/12. The Medication Administration Record also indicated the resident received the prn Hydromorphone at 5:30 a.m. This indicated the resident received the Hydromorphone at 5:30 a.m. and then again at 6:00 a.m. on 9/3/12.</p> <p>The "2010 Nursing Spectrum Drug Handbook" indicated Hydromorphone was classified as a potent opioid agonist with the risk of causing respiratory depression and instructions were to take the medication exactly as prescribed.</p>		<p>for 3 months. Trends will be reviewed in QA monthly times 3 months and quarterly thereafter to determine further education and/or monitoring needs. Tool will be turned into and monitored by the DON for completion. Identified non-compliance will result in one to one re-education up to and including termination. Any identified trends will be forwarded to the administrator for review and presented to QA to determine further educational needs.,.</p> <p>Systems Changes: Completed by 9/30/2012</p>				

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	<p>When interviewed on 9/7/12 at 9:00 a.m., the Director of Nursing indicated the resident received the medication in less than the ordered times. The Director of Nursing indicated the medication orders needed to be clarified.</p> <p>This Federal tag relates to Complaints IN00113982 and IN00115637.</p> <p>3.1-48(c)(2)</p>			

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F0514 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 record review and interview, the facility failed to ensure clinical record were accurate and complete related to signing out medications and skin assessments, completing wound forms, and follow-up documentation after an injury for 3 of 13 residents reviewed for accurate and complete clinical records in the sample of 13. (Residents #B, #G, and #H)</p> <p>Findings include:</p> <p>1. The record for Resident #H was reviewed on 9/6/12 at 1:50 p.m. The resident's diagnoses included, but were not limited to, depressive disorder, high blood pressure, and chronic kidney disease. Review of the 8/12 Treatment</p>	F0514	<p>F514 It is the practice of this facility to maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The facility failed to ensure clinical record were accurate and complete related to signing out medications and skin assessments, completing wound forms, and follow-up documentation after an injury. Corrective Action: An audit of resident H, G, and B, MAR and TAR was completed to ensure all medications and treatments were given/completed, and signed by the nurse indicating completion. Preventive Measures: All nurses will be re-educated on proper documentation in the MAR and TAR. Also, re-educated</p>	09/30/2012			

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	<p>Record indicated the resident was to have a weekly skin assessment completed on the 2:00 p.m. - 10:00 p.m. shift every Tuesday. The skin assessments were not signed out as completed on 8/14/12, 8/21/12, or 8/28/12.</p> <p>When interviewed on 9/6/12 at 3:35 p.m., the Director of Nursing indicated the weekly skin assessments should have been signed out as completed on the Treatment Record.</p> <p>2. The closed record for Resident #G was reviewed on 9/5/12 at 12:25 p.m. The resident's diagnoses included, but were not limited to, congestive heart failure, chronic obstructive pulmonary disease, malignant neoplasm of the prostate, diabetes, and atrial fibrillation (an irregular heart beat). The resident was admitted to the facility on 8/23/12 and was discharged to the hospital on 8/26/12.</p> <p>Review of the 8/12 Medication Administration Record indicated the resident was to receive Symbicort two puffs every 12 hours at 8:00 a.m. and 8:00 p.m., bicalutamide 50 milligrams one tablet daily at 8:00 a.m., folic acid 1 milligram every day at 8:00 a.m., furosemide 20 milligrams one tablet daily at 8:00 a.m., and lisinopril 10 milligrams one tablet daily at 8:00 a.m. The above</p>		<p>about the importance of episodic documentation on each shift until stabilized or the situation is otherwise resolved or for no less than 72 hours after episode. (reason for documentation). Monitoring: Each nurse will be checking the MAR and TAR at the end/beginning of each shift. Each nurse while giving report to the oncoming nurse will check the MAR and TAR of "holes" They will each sign the log indicating this was completed. The Unit Manager, ETD, DON, or designee will monitor this log before daily clinical review to ensure completeness. This log will be monitored for accuracy daily for 2 weeks, 3 times a week for 2 weeks, weekly for 8 weeks, then monthly for 3 months and monthly for 3 months. Trends will be reviewed in QA monthly times 3 months and quarterly thereafter to determine further education and/or monitoring needs. Tool will be turned into and monitored by the DON for completion. Identified non-compliance will result in one to one re-education up to and including termination. Any identified trends will be forwarded to the administrator for review and presented to QA to determine further educational needs., Systems Changes: Completed by 9/30/2012</p>		

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	<p>medications were not signed out as given on the Medication Administration Record on 8/24/12.</p> <p>When interviewed on 9/5/12 at 1:45 p.m., the Director of Nursing indicated she contacted the pharmacy and they indicated the resident's medications were delivered to the facility at 2:00 a.m. on 8/24/12.</p> <p>When interviewed on 9/5/12 at 4:45 p.m., LPN #1 indicated she had given the resident's morning medications on 8/24/12, but had not signed them out as given.</p> <p>3. The record for Resident #B was reviewed on 9/5/12 at 1:45 p.m. The resident's diagnoses included, but were not limited to, malignant brain neoplasm and convulsions. The 7/17/12 Minimum Data Set (MDS) admission assessment indicated the resident required extensive assistance of two staff members for bed mobility, transfers, dressing, personal hygiene, and toileting.</p> <p>Review of a 7/28/12 Resident Incident report indicated an incident occurred at 1:00 a.m. The report indicated the resident was left on the bedpan and staff observed a bruise on the resident's left buttock measuring 0.2 cm (centimeters)</p>						

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	<p>"thick" and 15.2 cm in length and a second bruise to the right buttock measuring 0.2 cm "thick" and 15.4 cm in length was also noted. Both of the above areas were noted to be reddish purple in color. The report described the pain as "hurts little bit."</p> <p>Review of the 7/28/12 Nurses' Notes indicated the first entry was made at 1:00 a.m. This entry indicated the resident was resting in bed with her eyes closed and the call light was in reach. There was no documentation of the resident being observed on the bed pan or the bruises she obtained from the above incident. The next entry was made at 10:45 p.m. This entry indicated the resident was resting in bed and was orientated x 2 with some confusion. There was no documentation of the areas observed on the resident's bilateral buttock areas.</p> <p>The next entry in the Nurses' Notes was made on 7/29/12 at 6:25 a.m. There was no assessment of the resident's injuries in this entry. The next entry was made on 7/29/12 at 2:00 p.m., and indicated "area to the buttocks remains same..." The next entry was made at 10:20 p.m. There was no documentation of the injuries in this entry. The next entries were made on 7/30/12. There was no time listed on the first entry. The next entries were made at</p>			

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	<p>2:35 p.m. and 10:00 p.m. There was no documentation of the bruise areas in the 7/30/12 entries.</p> <p>Two "Skin Grid -Pressure/Venous Insufficiency Ulcer/Other" forms were initiated on 7/28/12. The first form indicated the Stage II area was initially identified on the resident's right buttock measuring 15.4 cm x .2 cm, the wound color was red and there was no drainage or odor. The next entry on this form was dated 7/31/12. The same measurements and assessments were documented. The next entry was made on 8/7/12 and this entry indicated the area was a Stage I and measured 12 cm x .2 cm with no drainage or odor.</p> <p>The second form indicated a Stage II area was initially identified to the resident's left buttock and measured 15.2 cm x .2 cm and was red in color with no drainage of odor present. The next entry was made on 7/31/12 and the same measurements as those of the 7/28/12 assessment was documented. The next entry was made on 8/7/12 and the area measured 8.4 cm x .1 cm and the wound color was pink with no drainage or odor noted.</p> <p>The facility policy titled "Episodic Documentation" was received from the Assistant Director of Nursing on 9/5/12 at</p>						

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NAME OF PROVIDER OR SUPPLIER MICHIANA HEALTH AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 1420 E DOUGLAS RD MISHAWAKA, IN 46545			
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	<p>5:00 p.m. The policy had a revised date of July 2012. The policy indicated staff were to "document significant resident care issues each shift until stabilized or the situation is otherwise resolved." The policy indicated the staff were to enter the date and time of the occurrence and facts regarding the incident and the episodic documentation was to continue every shift for a minimum of 72 hours for significant resident care issues.</p> <p>When interviewed on 9/5/12 at 3:58 a.m., the Assistant Director of Nursing indicated the wounds were reported to her as scabbed areas on both buttocks. The Assistant Director of Nursing indicated she first observed the areas after 7/31/12. The Assistant Director of Nursing indicated she made the 7/28/12 and the 7/31/12 entries on the Skin Grid reports based on the original measurements that were reported to her. The Assistant Director of Nursing indicated she did not measure the area on 7/31/12. She also indicated any scabbed area "we stage as Stage II."</p> <p>When interviewed on 9/5/12 at 5:00 p.m., the Director of Nursing indicated staff should have completed documentation related to the resident's injuries as per the policy.</p>						

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	<p>This Federal tag relates to Complaints IN00113432 and IN00115637.</p> <p>3.1-50(a)(1) 3.1-50(a)(2)</p>			

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F9999	<p>STATE RULES</p> <p>3.1-14 PERSONNEL</p> <p>(q) Each facility shall maintain current and accurate personal records for all employees. The personnel records for all employees shall include the following:</p> <p>(7) Documentation of orientation to the facility and the specific job skills.</p> <p>This state rule was not met as evidenced by:</p> <p>The Employee Files of the facility LPN's and RN's were reviewed for Job Specific orientation on 9/6/12 at 11:00 a.m., with the Staff Development Nurse. The Staff Development Nurse provided Competency Skills checklists and Evaluations and indicated they were to be completed during the orientation of all LPN's and RN's who were to provide care to the residents. Fourteen (14) of the 26 LPN's who worked on the units did not have completed or current evaluations. Four (4) of 10 RN's who worked on the units did not have completed or current evaluations</p> <p>The Employee Files indicated Evaluations were not completed or were completed</p>	F9999	<p>F9999 It is the practice of this facility to maintain current and accurate personnel records for all employees.</p> <p>Corrective Action: All active employee's personnel files will be audited to ensure that the orientation to facility and specific job skills checklist are complete. The orientation to facility and skills checklist will be completed during the employee's orientation period and maintained in the employee's personnel file.</p> <p>Preventative Measures: The Educational Training Director and the Accounts Payable Manager will be educated on the need to develop and maintain a tracking checklist to ensure that the appropriate documentation is completed timely.</p> <p>Monitoring: Accounts payable will conduct a monthly audit review of all new hires for the past 30 days. Educational Training Director will implement a tickler system to identify those employees needing annual review of skills validation. The monthly review and tickler system will be checked weekly for 3 months and then monthly for 3 months by the administrator. Trends will be reviewed in QA monthly times 3 months and quarterly thereafter to determine further education and/or monitoring needs. Identified non-compliance will result in one to one re-education</p>	09/30/2012	

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	<p>late for the following Nurses:</p> <p>LPN's</p> <p>#1- hired on 5/4/11- signed 8/31/12 #2- hired on 10/12/11- signed 8/1/12 #3- hired on 3/1/12- signed 8/31/2 #4- hired on 7/2/12- signed 8/28/12 #5- hired on 4/10/12 - not signed yet #6- hired on 3/1/12- not signed yet #7- hired on 11/8/11- signed 9/6/12 #8- hired on 5/24/12 - signed but not dated #9- hired on 5/24/12 - signed but not dated #10- hired on 6/2012 - signed 8/31/12 #11- hired on 5/4/11 - signed 8/11/12 #12- hired on 12/8/11- signed 7/3/12 #13- hired on 6/21/11- signed 8/15/12 #14- hired on 5/17/11- signed on 9/4/12</p> <p>RN's</p> <p>#1- hired on 2/8/12- not signed yet #2- hired on 10/25/11- signed 8/1/12 #3- hired on 11/30/10- not signed yet #4- hired on 4/13/11- signed 8/15/12</p> <p>When interviewed on 9/6/12 at 11:30 a.m., the Staff Development Nurse indicated she started covering for the previous Staff Development Nurse around June 2012 when that Nurse was on a medical leave. The Staff Development Nurse indicated she then began noticing that Competency Skills lists and evaluations were not located in the</p>		<p>up to and including termination. Any identified trends will be forwarded to the administrator for review and presented to QA to determine further educational needs,.</p> <p>System Changes: Completed by 9/30/12</p>				

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	<p>Nurses' files. She indicated she could not locate them so began informing the DON and the Administrator and then began reviewing all files. She also contacted the Pharmacy IV Nurse and a Respiratory Therapist to set up training. The Staff Development Nurse indicated the facility conducted a Competency Skill day in July and several Nurses attended. She indicated she also gave the lists to Unit Managers to have them completed. The Staff Development Nurse indicated all the Competency Skills List should be completed prior to the the Nurses working independently on the units.</p> <p>This state tag relates to Complaints IN00113982 and IN00115637.</p> <p>3.1-14(q)(7)</p>			