

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155482	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/01/2013
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NAME OF PROVIDER OR SUPPLIER KENDALLVILLE MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 1802 E DOWLING ST KENDALLVILLE, IN 46755
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F0000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: January 28, 29, 30, 31, & February 1, 2013</p> <p>Facility number: 000529 Provider number: 155482 AIM number: 100267140</p> <p>Survey team: Rick Blain, RN - TC Tim Long, RN Carol Miller, RN Diane Nilson, RN</p> <p>Census bed type: SNF/NF: 34 Total: 34</p> <p>Census bed type: Medicare: 4 Medicaid: 20 Other: 10 Total: 34</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on Febtruary 5, 2013 by Randy Fry RN.</p>	F0000	<p>This plan of correction is to serve as Kendallville Manor's credible allegation of compliance. Submission of this plan of correction does not constitute an admission by Kendallville Manor or their management companies that the allegations contained in the survey report are a true and accurate portrayal of the provision of nursing care and other services in this facility. Nor does this submission constitute an agreement or admission of the survey allegations</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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F0160 SS=B	<p>483.10(c)(6) CONVEYANCE OF PERSONAL FUNDS UPON DEATH</p> <p>Upon the death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate.</p> <p>Based on interview and record review, the facility failed to disperse personal funds, post discharge from the facility, in a timely manner, for 1 of 3 discharged residents (#36) reviewed for personal funds.</p> <p>Findings include:</p> <p>An interview with Employee #4, the Business Office Manager, on 1/31/13 at 1:30 P.M. indicated Resident #36 was discharged from the facility on 9/23/12 and the facility was managing the resident's personal funds. Employee #4 indicated the personal funds for Resident #36 were not dispersed until 12/21/12.</p> <p>3.1-6(h)</p>	F0160	<p>F160 483.10(c)(6) Conveyance of Personal funds upon Death.</p> <p>Our facility strives to ensure the highest quality care to our residents In accordance with that policy we will address the following issues.</p> <p>I. Resident #36 trust fund balance was refunded to the individual administering the estate on 12/21/12. All trust fund accounts were audited as of 2/21/13.</p> <p>II. Resident trust accounts for deceased residents are reviewed on the business day following notice of death with final reconciliation, refund and final accounting sent to the individual administering the residents estate with the 30 (thirty) day conveyance period.</p> <p>BOM will audit resident trust reconciliation while performing resident trust fund account audits weekly. Findings will be reported to the Quality Assurance Committee.</p> <p>Monitoring will then become a function of the Quality Assurance Committee overseen by the administrator.</p>	03/21/2013
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F0279 SS=D	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on observation, record review, and interview, the facility failed to develop a plan of care to address an injury and treatment for 1 of 3 residents reviewed who met the criteria for non-pressure related skin conditions (Resident #19) . The facility also failed to develop a care plan to address aggressive behavior for one resident (Resident #30) in a sample of 20 residents reviewed for care plans.</p> <p>Findings include:</p>	F0279	<p>F279 483.20 (k) (1) DEVELOP COMPREHENSIVE CARE PLANS It is the practice of Kendallville Manor to review and revise the resident's comprehensive care plan.</p> <p>I. Resident 19 has been reviewed and care plan updated. It is noted that there was a care plan initiated on 1-16-13 "Resident has skin tear to left forearm and hand". (Attachment # 1)</p> <p>II. Care Plans have been reviewed to insure that all areas are addressed (Attachment # 2)</p>	03/21/2013	

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	<p>1. During observation of Resident #19, at 2:35 p.m., on 1/28/13, the resident was noted to have a clear dressing on top of his left hand.</p> <p>The record for Resident #19 was reviewed at 2:40 p.m., on 1/29/13. A physician's order, dated 1/16/13, indicated tegaderm was to be applied to the left forearm and hand and changed every 3 days until healed.</p> <p>A nursing note, dated 1/16/13, at 10:00 p.m., indicated an order was received for tegaderm to be applied to the skin tears on the resident's left forearm and hand, but there was no assessment regarding the skin tears. A nursing note, dated 1/28/13, at 11:00 a.m., indicated the left hand where tegaderm was applied had a small open area and inflammation.</p> <p>Review of the care plan , dated 12/19/12 indicated the resident had a potential for impaired skin related to immobility, but there was no specific care plan for the skin tears on the hand and forearm.</p> <p>The Director of Nursing Services was interviewed at 8:45 a.m., on 1/30/13, and indicated there was a care plan for potential skin integrity, but an individual care plan should have been</p>		<p>III. The DON or her designee is conducting care plan audits. A random sample of 2 residents are being reviewed weekly for 4 weeks, then monthly thereafter to insure that the care plan has been completed and concerns have been appropriately addressed. Results of these audits are being reported in the facility QA Committee Meeting for additional recommendation as necessary. (Attachment #2)</p> <p>IV. The nursing staff has been reeducated on the proper reporting of injuries to include falls and skin tears. As well, review the policy on Falls/Incident Management. (Attachment # 3 and # 4)</p> <p>V. The Interdisciplinary Care plan team has been reeducated on the facility's policy regarding care plans. IDT team conducts daily clinical meetings to include new Incident Reports and interventions deemed necessary and changes in the care plans. (Attachment # 5, #6, #7 and # 8)</p> <p>VI. New admissions to the facility are being reviewed within 24 hours of the IDT meeting to insure an admission plan of care has been implemented. As well, the Social Services Designee reviews medication, diagnosis and any reported behaviors. A care plan is implemented at that time.</p> <p>VII. A resident with a known behavior is also placed</p>		

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	<p>written regarding the injury to the resident's hand and forearm.</p> <p>Review of the Falls/Incident Management policy at 10:00 a.m., on 2/1/13, and provided by the Director of Nursing Services at 4:15 p.m., on 1/30/13, indicated when an incident occurs, it must be reported to the charge nurse. The charge nurse must fill out an incident report completely and must chart a detailed assessment in the nurse's notes. The policy indicated, "This may include:</p> <ul style="list-style-type: none"> A description of the incident Any injuries, including measurements and treatments Family and physician notification Events that may have precipitated the incident. " <p>The policy further indicated the incident report would be reviewed by the interdisciplinary team the next business day. At that time, the resident chart would be reviewed and any interventions deemed necessary would be implemented, and the care plan would be updated to reflect any changes.</p>		<p>into the behavior book with interventions for all staff to document any behaviors that occurs. This book is reviewed during the daily clinical meeting. Care Plans and Behavior book are reviewed if deemed necessary changes are completed. (Attachment # 6, #7 and # 8)</p> <p>VIII. The nursing staff has been reeducated on the proper reporting and documenting of behaviors on log (Attachment # 9 and # 10)</p>		

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	<p>2. The record for Resident #30 was reviewed on 1/30/13 at 10:30 A.M. Diagnoses included, but were not limited to, dementing illness with associated behavior symptoms.</p> <p>A physician order monthly re-cap for January 2013 indicated Resident #30 was prescribed Geodon (medication used to treat psychiatric conditions) 20 mg (milligrams) twice daily.</p> <p>A nursing note, dated 11/8/12 at 7:00 P.M., indicated "...advised that resident pushed and hit LPN."</p> <p>A nursing note, dated 11/8/12 at 8:00 P.M., indicated "(Resident) then started hitting me on the arm to shoulder & pushing me (sic). She continued hitting me & I told her to stop. She then ran to her room & threw the garbage can & went in the bathroom."</p> <p>A physician progress note, dated 1/10/2013, indicated "Continue medications as needed for psychosis and agitative (sic) behavior...."</p> <p>There was no indication in Resident</p>			

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	<p>#30's record to indicate a care plan for aggression had been developed or implemented.</p> <p>The facility's Social Service Designee was interviewed on 1/30/13 at 11:00 A.M. During the interview, the Social Service Designee indicated Resident #30 had a history of being combative and aggressive toward staff. The Social Service Designee indicated residents with aggressive behaviors should have a care plan to address those behaviors. The Social Service Designee further indicated a care plan to address Resident #30's physical aggression had not been developed.</p> <p>A facility policy on care planning, dated 10/2010, indicated "Our facility's Care Planning/Interdisciplinary Team is responsible for the development of an individualized comprehensive care plan for each resident."</p> <p>3.1-35(a)</p>				

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F0280 SS=D	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>Based on record review and interview, the facility failed to ensure two residents' legal representatives were invited to participate in care plan conferences . This deficient practice affected 2 of 2 residents reviewed for participation in care plan meetings (Resident #25 and Resident #40).</p> <p>Findings include:</p> <p>1. A family member of Resident # 25 was interviewed, at 2:10 p.m., on 1/28/13, and indicated she was the resident's legal representative and used to be invited to attend the care conferences for the resident, but had</p>	F0280	<p>F280 483.20(d)(3). 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP It is the practice of Kendallville Manor to develop a comprehensive care plan within 7 days after completion of the comprehensive assessment; prepared by the IDT, which includes the attending physician, registered nurse, and other appropriate staff in disciplines as determined by the resident's needs, and the extent practicable, the participation of the resident, the resident's family or legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p>	03/21/2013	

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	<p>not received an invitation to attend the care conferences for some time. The resident was in the room at the time of the family interview, but was not able to communicate verbally.</p> <p>The resident record was reviewed at 10:00 a.m., on 1/30/13, and indicated the resident was readmitted to the facility on 9/19/11, with diagnoses including, but not limited to Cerebral Vascular Accident with aphasia.</p> <p>Review of the Care plan meeting book, at 10:15 a.m., on 1/30/13, for Resident # 25 indicated the most recent care plan meeting was held on 6/18/12. There were 6 people in attendance at this meeting, one of these being the resident and one the resident's legal representative.</p> <p>The Social Service Designee was interviewed, at 10:15 a.m., on 1/30/13, and indicated she had only worked as the Social Service Designee for one month and was still in training for the position. She indicated if there was a care plan meeting, it should be documented in the care plan book with signatures of all in attendance. She indicated she did not know how the previous social worker notified families of the care plan meetings, but since she had</p>		<p>I. The IDT team has been reeducated on the facility's policy regarding care plans and IDT meetings. The facility conducts daily clinical meetings. (Attachment # 5, # 6, # 7, #8 #11 and # 12)</p> <p>II. Each resident's care plan will be reviewed at least quarterly or when there is a significant change, desired outcome is not met, or readmission from a hospitalization.</p> <p>III. Care Plans have been completed on Resident # 25 and # 40 with family members. (Attachment # 13 and # 14).</p> <p>IV. Social Service Designee is scheduling Care plan in accordance to facility policy at least quarterly, significant change or desired outcome not being met or readmission from the hospital with resident to include family member or legal representative. (Attachment # 15).</p> <p>V. Social Services Designee scheduled and completed care plans per facility policy. (Attachment # 16).</p> <p>VI. The DON or her designee is conducting care plan audits. A random sample of 2 residents are being reviewed weekly for 4 weeks, then monthly thereafter to insure that the care plan has been completed and concerns have been appropriately addressed. Results of these audits are being reported in the facility QA Committee Meeting for</p>		

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	<p>taken over the position, she had begun sending letters to families regarding the meetings.</p> <p>The Director of Nursing Services (DNS) was interviewed, at 10:40 a.m., on 1/30/13, and indicated she had been the DNS since July, 2012. She indicated she attended the care plan meeting for Resident #25 on 6/18/12 because her signature was documented on 6/18/12 on the care conference attendance sheet. She indicated she had not attended a care plan meeting on Resident #25 since 6/18/12.</p> <p>The Administrator was interviewed, at 3:30 p.m., on 1/30/13, and indicated the previous Social Service person left in November, 2012, and the Activity Director was filling in for her, until 1 month ago when the current Social Service Designee started working in that position. The Administrator indicated the new Social Service Designee had been receiving training from other social service personnel from other affiliated facilities. She indicated the Social service person was responsible for scheduling the care plan meetings with the resident and families and the previous social service person had</p>		additional recommendation as necessary. (Attachment # 2).		

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	<p>not been doing this. She indicated the new Social Service Designee and the Minimum Data Set (MDS) Coordinator would now be scheduling the care plan meetings, and the Social Service Designee would be sending out letters to the families. She further indicated with changing around of department heads, there had not been a good system in place regarding scheduling the care plan meetings.</p> <p>The Administrator (Date of Hire 8/1/12) indicated she realized the care plan meetings were not being scheduled or held in November, 2012 while the previous Social Service person was still employed at the facility. She indicated issues were being discussed with resident families but not according to facility policy for formal care plan meetings.</p> <p>Review of the Care Planning-Interdisciplinary Team Policy, provided by the Administrator at 11:00 a.m., on 1/30/13, indicated the Care Planning/Interdisciplinary Team included "but is not necessarily limited to the following personnel": the resident's attending physician The registered nurse who was responsible for the resident The Dietary Manager/Dietitian Therapists</p>			

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	<p>Consultants The Director of Nursing Nursing Assistants.</p> <p>The policy indicated the resident, the resident's family and/or the resident's legal representative/guardian or surrogate were encouraged to participate in the development of and revisions to the resident's care plan. The resident and/or responsible party would be invited to participate in the quarterly review of the residents overall plan of care. Record of this invitation would be maintained in the resident's clinical record. Also, each resident's care plan would be reviewed at least quarterly.</p> <p>2. On 1/28/13 at 3:35 p.m. Resident #40's Power of Attorney was interviewed and indicated she had never been invited to the residents care planning conferences.</p> <p>Resident # 40's record was reviewed on 1/30/13 at 11:45 a.m., and indicated Resident # 40 was admitted to the facility on 5/8/12.</p> <p>The Social Service Notes did not indicate when the last care planning</p>						

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	<p>conference was done.</p> <p>The Care Conference Attendance form dated 5/24/12 and was signed by the past Social Service Designee and the Activity Director (AD), the 8/23/12 and the 11/1/12 was signed by the AD.</p> <p>Interview on 1/30/13 at 2 p.m. with the Social Service Designee (SSD) indicated she had started the position of SSD in the middle of December and had identified in the QAA meeting in the middle of December 2012. that care conferences were not being done. The SSD further indicated she was unsure when the last care conference for Resident #40 was done.</p> <p>3.1-35(c)(A)(B)(C)</p>				

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F0309 SS=D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on observation, record review, and interview, the facility failed to ensure an assessment was completed and documented regarding an injury to a resident's hand and forearm. This deficient practice affected 1 of 2 residents reviewed for skin conditions unrelated to pressure ulcers (Resident #19).</p> <p>Findings include:</p> <p>During observation of Resident #19, at 2:35 p.m., on 1/28/13, the resident was noted to have a clear dressing on top of his left hand.</p> <p>The record for Resident #19 was reviewed at 2:40 p.m., on 1/29/13. A physician's order, dated 1/16/13, indicated tegaderm was to be applied to the left forearm and hand and changed every 3 days until healed.</p> <p>A nursing note, dated 1/16/13, at 10:00 p.m., indicated an order was received for tegaderm to be applied to</p>	F0309	<p>F309 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING It is the practice of Kendallville Manor to follow facility policy in regards to completing and reporting accident/incident reports.</p> <p>I. The nursing staff has been reeducated on the proper reporting of injuries to include falls and skin tears. As well, review the policy on Falls/Incident Management. (Attachment # 3 and # 4)</p> <p>II. Resident 19 has been reviewed and care plan updated. It is noted that there was a care plan initiated on 1-16-13 "Resident has skin tear to left forearm and hand". (Attachment # 1)</p> <p>III. The Interdisciplinary Care plan team has been reeducated on the facility's policy regarding care plans. IDT team conducts daily clinical meetings to include new Incident Reports and interventions deemed necessary and changes in the care plans. (Attachment # 5, #6, #7 and # 8)</p> <p>IV. The DON or her</p>	03/21/2013	

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	<p>the skin tears on the resident's left forearm and hand, but there was no assessment regarding the skin tears. A nursing note, dated 1/28/13, at 11:00 a.m., indicated the left hand where tegaderm was applied had a small open area and inflammation.</p> <p>The Director of Nursing Services (DNS) was interviewed at 3:14 p.m., on 1/29/13, and indicated the area on the resident's left hand started when a blood draw was completed. She provided an incident report regarding the skin tear on the resident's forearm, at 3:18 p.m., on 1/29/13. Review of the incident report, at 3:20 p.m., on 1/29/13, indicated the incident occurred on 1/16/13, at 12 noon. The report indicated a Certified Nursing Assistant (CNA) notified the nurse at 1:30 p.m., on 1/16/13, that she had noticed the skin tear during lunch in the dining room. The incident report indicated there was a laceration, and the physician was notified and tegaderm was ordered for left forearm. The investigation attached to the incident report indicated there was a skin tear to the left forearm, 2 CNAs had transferred the resident to his broda chair at 11 a.m., on 1/16/13, and there was no bleeding or drainage noted. The incident report indicated the 2</p>		<p>designee is conducting care plan audits. A random sample of 2 residents are being reviewed weekly for 4 weeks, then monthly thereafter to insure that the care plan has been completed and concerns have been appropriately addressed. Results of these audits are being reported in the facility QA Committee Meeting for additional recommendation as necessary. (Attachment #2)</p>		

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	<p>CNAs did not notice the resident strike anything and one of the CNAs commented that due to them using gait belts, the resident's arm may have come in contact with the gait belt.</p> <p>There was no documentation in the nursing notes or incident report regarding an assessment being completed of the hand, or information regarding what the area looked like or the size of the laceration/skin tear.</p> <p>At 8:45 am on 1/30/13, DNS indicated she had investigated further on 1/29/13. She indicated she was made aware of the skin tear on the resident's forearm on 1/17/13. She indicated she had talked to the CNAs and they indicated there was also a red area on the resident's hand due to a blood draw. The DNS indicated she looked at the resident's hand on 1/17/13 and there was a tegaderm dressing on the hand. She indicated there was an area on the top of the vein on the hand which looked a little red, and she thought it was from a blood draw.</p> <p>The DNS indicated she had contacted the lab but could not determine where the blood was drawn from, so was not sure if this caused the injury to the resident's hand. She indicated she</p>						

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	<p>talked to the nurse who was working when the incident occurred, and the nurse indicated she did not have time to document the incident regarding the injury to the resident's left hand and forearm, but did call the physician and get a treatment for the areas. She indicated she passed the information on to the second shift nurse, but she didn't document or further assess the areas.</p> <p>The DNS indicated the nurse should have measured and assessed the area on the resident's hand and forearm, but did not.</p> <p>The DNS indicated there was a care plan for potential skin integrity, but an individual care plan should have been written regarding the injury to the resident's hand and forearm.</p> <p>Review of the undated Falls/Incident Management policy at 10:00 a.m., on 2/1/13, and provided by the Director of Nursing Services at 4:15 p.m., on 1/30/13, indicated when an incident occurs, it must be reported to the charge nurse. The charge nurse must fill out an incident report completely and must chart a detailed assessment in the nurse's notes. The policy indicated, "This may include: A description of the incident Any injuries, including</p>			

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	<p>measurements and treatments Family and physician notification Events that may have precipitated the incident. " The policy further indicated the incident report would be reviewed by the interdisciplinary team the next business day. At that time, the resident chart would be reviewed and any interventions deemed necessary would be implemented, and the care plan would be updated to reflect any changes.</p> <p>3.1-37(a)</p>			

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F0323 SS=D	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on interviews and record review, the facility failed to ensure the policy for gait belt use was followed for 1 resident who fell during a transfer from the wheelchair to the bed. This deficiency affected 1 of 2 residents who were reviewed for falls (Resident #65).</p> <p>Findings include:</p> <p>Resident #65's record was reviewed on 1/30/13 at 9:30 a.m., and indicated Resident #65's diagnosis included, but were not limited to, dementia and anxiety. The resident was admitted to the facility on 1/25/13 through 1/29/13 for respite care.</p> <p>The Admission Nursing Assessment dated 1/25/13 at 1:30 p.m. indicated the resident was at high risk for falls.</p> <p>Nurses Notes 1/26/13 at 3:30 p.m. indicated the resident was lowered to the floor by staff and the resident was assessed and did not sustain any injury.</p>	F0323	<p>F323 483.25(h) FREE OF ACCIDENT HAZARDS, SUPERVISION AND DEVICES It is the practice of Kendallville Manor to follow the facility policy regarding Gait Belt Transfers in efforts to provide an accident free environment and prevent unnecessary accidents. I. Nursing staff has been reeducated on the facility's policy on use of gait belts during transfers (Attachment # 17) II. Facility's policy on Gait Belt Transfers reviewed by staff. (Attachment # 18) III. Admission Check Off List has a new item that a new admit be added the C.N.A. assignment sheets in efforts to be able to meet the resident's safety needs. (Attachment # 19) IV. The DON or her designee is conducting care plan audits. A random sample of 2 residents are being reviewed weekly for 4 weeks, then monthly thereafter to insure that the use of gait belts is enforce. (Attachment # 20) Results of these audits are being reported in the facility QA Committee Meeting for additional recommendation as necessary.</p>	03/21/2013			

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	<p>The Incident and Accident form dated 1/26/13 at 1:00 p.m. was reviewed on 2/1/13 at 8:30 a.m., and indicated CNA #1 and CNA #2 had transferred Resident #65 from the wheelchair to the side of the bed the bed was unlocked and moved as the resident's knees buckled and the 2 CNAs lowered the resident from the side of the bed to the floor. The Incident/Accident form further indicated the CNAs should had used a gait belt during the transfer of the resident from the wheelchair to the bed.</p> <p>On 1/30/13 at 12:00 p.m. CNA #1 was interviewed in regard to Resident #65's fall and indicated a gait belt should had been used on the resident during the transfer from the wheelchair to the bed.</p> <p>On 1/31/13 at 8:30 a.m. Director Nursing Services (DNS) was interviewed and indicated a gait belt should had been used by CNA's #1 and #2 during the transfer of Resident #65 .</p> <p>On 2/1/13 at 9:00 a.m. the DNS was interviewed and indicated the resident's bed was in the lowest position and should had been locked</p>				

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	<p>prior to the transfer.</p> <p>The Gait Belt Transfers policy dated 1/2011 received from the DNS on 1/31/13 at 8:30 a.m. indicated "...Unless otherwise noted in the residents care plan, a gait belt should be utilized for all residents during manual transfers."</p> <p>3.1-45(a)(2)</p>				

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F0329 SS=D	<p>483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on interview and record review, the facility failed to ensure one resident had been assessed for anxiety prior to and after the administration of an antianxiety medication. This deficiency affected 1 of 10 residents reviewed for unnecessary medication (Resident #15). The facility failed also to develop a behavior tracking log to identify, record, and monitor the behaviors for one resident. This deficient practice affected 1 of 10</p>	F0329	<p>F329 483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>It is the practice of Kendallville Manor to follow the facility policy on Anti-Psychotic Medication Use in efforts to minimize the use of unnecessary drugs , excessive duration or without adequate monitoring.</p> <p>I. Staff has been reeducated on the facility policy and the procedures to follow when assessing and administering a PRN antipsychotic medication</p>	03/21/2013	

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	<p>residents reviewed for unnecessary medications (Resident #30).</p> <p>Findings include:</p> <p>1. Resident #15's record was reviewed on 1/30/13 at 2:00 p.m., and indicated Resident #15's diagnosis included, but were not limited to, anxiety.</p> <p>The Physician's Order Sheet dated January 2013 indicated the resident was to receive Ativan 0.5 milligrams as needed at bedtime for anxiety.</p> <p>The January 2013 Medication Administration Record (MAR) indicated the medication Ativan was documented as given to Resident #15 on 1/13/13 and 1/17/13. There was no documentation on the back of January 2013 MAR.</p> <p>The Nurse's Notes dated 1/13/13 and 1/17/13 did not indicate why the resident had received the medication Ativan or if the Ativan had been effective. There was also no indication on the back of the MAR for January 2013 to indicate why the Ativan had been administered.</p> <p>Interview with the Director Nursing Service (DNS) on 1/31/13 at 1:30</p>		<p>(Attachment #21 and # 22)</p> <p>II. Implemented an Anti-Anxiety Management Flow Sheet on 2-1-13. (Attachment # 23) The flow sheet is to be used as an assessment tool in which the resident's anxiety level can be assessed, Interventions to include Non-medicinal interventions as well as effectiveness of treatment.</p> <p>III. The DON or her designee is conducting PRN Anti-Anxiety audits. A random sample of 2 residents are being reviewed weekly for 4 weeks, then monthly thereafter to insure that the care plan has been completed and concerns have been appropriately addressed. Results of these audits are being reported in the facility QA Committee Meeting for additional recommendation as necessary. (Attachment #24)</p>		

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	<p>p.m. in regard to Resident #15's as needed Ativan and indicated the Nurses should had assessed the resident prior to the administration of the medication Ativan. The DNS further indicated non pharmacological interventions should had been tried on the resident prior to giving the Ativan and the nurse should had documented the effectiveness after the Ativan had been administered in either the Nurse's Notes or on the back of the MAR.</p> <p>2. The record for Resident #30 was reviewed on 1/30/13 at 10:30 A.M. Diagnoses included, but were not limited to, dementing illness with associated behavior symptoms.</p> <p>A physician order monthly re-cap for January 2013 indicated Resident #30 was prescribed Geodon (medication used to treat psychiatric conditions) 20 mg (milligrams) twice daily.</p> <p>A nursing note, dated 11/8/12 at 7:00 P.M., indicated "...advised that resident pushed and hit LPN."</p> <p>A nursing note, dated 11/8/12 at 8:00</p>				

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	<p>P.M., indicated "(Resident) then started hitting me on the arm to shoulder & pushing me (sic). She continued hitting me & I told her to stop. She then ran to her room & threw the garbage can & went in the bathroom."</p> <p>A physician progress note, dated 1/10/2013, indicated "Continue medications as needed for psychosis and agitative (sic) behavior...."</p> <p>There was no indication in Resident #30's record to indicate a behavior monitoring log for aggression had been developed or implemented.</p> <p>The facility's Social Service Designee was interviewed on 1/30/13 at 11:00 A.M. During the interview, the Social Service Designee indicated Resident #30 had a history of being combative and aggressive toward staff. The Social Service Designee indicated residents with aggressive behaviors were to have a behavior tracking log in the behavior book so staff could record any behaviors. The Social Service Designee indicated a resident's target behaviors (those behaviors being monitored to assess the effectiveness of psychotropic medications) were to be listed on a behavior monitoring log and the</p>				

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	<p>facility staff would review the log to assess for the effectiveness of psychotropic medications. The Social Service Designee further indicated a behavior monitoring log Resident #30 had not been developed.</p> <p>An undated facility policy on behavior tracking was provided by the facility Executive Director on 1/31/13 at 1:15 P.M. The policy indicated "It is the policy of this facility to track and record observed behaviors...on the resident's Behavior Tracking Log." The policy further indicated "The Director of Social Services or designee shall systematically place the Behavior Tracking Logs in the Behavior Management Binder located at each nurse station on, or before, the initial start-up day and shall maintain an adequate supply of the Tracking Logs at all times." The policy also indicated "Each Tracking Log shall contain a description of the exact behavior being tracked...."</p> <p>3.1-48(a)(3) 3.1-48(a)(4)</p>				

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F0465 SS=E	<p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON</p> <p>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>Based on observation, record review, and interview, the facility failed to ensure a sanitary environment was maintained in resident bathrooms on 2 of 2 halls.</p> <p>Findings include:</p> <p>During the environmental tour of the facility, accompanied by the Maintenance Director, at 1:55 p.m. , on 1/30/13, the following was observed:</p> <p>On the 100 hall:</p> <p>1. In the bathroom, in room 112, there were dark stained areas on the linoleum floor in front of the toilet effecting 4 of the linoleum floor tiles. The Maintenance Director indicated he had tried to buff the stains out, but couldn't remove the stains from the tile.</p> <p>On the 200 hall, the following were observed:</p> <p>2. In the adjoining bathroom between Resident occupied rooms 207/209,</p>	F0465	<p>F465 Safe/Functional/Sanitary/Comfortable Environment It is the practice of Kendallville Manor to provide a safe, functional, sanitary, and comfortable environment for residents, staff and public. I. A plan of room readiness list for maintenance/remodeling was provided to the team. An updated room readiness list is attached. (Attachment # 26) II. Room # 112 is set to have bathroom floor stripped and re-waxed starting week of 2-25-13. III. Bathroom in adjoining Room # 207 and 209 is set to have floor stripped and re-waxed starting week of 2-25-13. IV. Room # 211 and # 213 adjoining bathroom is set to have floor stripped and re-waxed starting week of 2-25-13. The toilet has been reset and caulking applied to the base of the toilet. V. Room # 215 is set to have the floor stripped and re-waxed starting week of 2-25-13. Toilet was caulked. VI. Room # 212 faucet was repaired 2-12-13. VII. The Room Readiness list will be updated every week and results will be reported in the facility QA Committe Meeting for additional recommendation as necessary.</p>	03/21/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155482	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/01/2013
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NAME OF PROVIDER OR SUPPLIER KENDALLVILLE MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 1802 E DOWLING ST KENDALLVILLE, IN 46755
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	<p>there were 6 linoleum tiles around the base of the toilet that were discolored, and stained.</p> <p>The Maintenance Director indicated he didn't know what caused the discoloration, but the tile needed to be replaced.</p> <p>There were also brown stains directly around the base of the toilet.</p> <p>There was chipped and/or torn paint all around the sink area, directly above the back splash of the sink.</p> <p>3. In the adjoining bathroom between rooms 211/213, the linoleum tile on the floor was stained all around the toilet, in front of the toilet, and under the sink area. There were brown stains directly around the base of the toilet and the caulking on the left side of the toilet base was cracked and breaking away from the toilet base. The Maintance Director indicated the toilet needed to be reset and caulked.</p> <p>4. In the bathroom in resident room 215, there were 7 linoleum tiles in front and around the toilet that were light black stained .</p> <p>5. In resident room 212, when the water was turned on, water was leaking out from the bathroom faucet on the sink, and the Maintenance Director indicated this needed to be</p>			

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	<p>repaired.</p> <p>The Maintenance Director was interviewed, at 9:45 a.m., on 2/1/13 and indicated he didn't have a set schedule for maintenance of resident rooms. He indicated the Director of Nursing Services checked the rooms daily and reported in the morning meetings if any repairs were needed.</p> <p>3.1-19(f)</p>				