

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155218	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/31/2014
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NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHABILITATION-DYER	STREET ADDRESS, CITY, STATE, ZIP CODE 2300 GREAT LAKES DR DYER, IN 46311
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: October 27, 28 29, 30 & 31, 2014</p> <p>Facility number: 000123 Provider number: 155218 AIM number: 100266720</p> <p>Survey team: Cynthia Stramel, RN-TC Lara Richards, RN Heather Tuttle, RN Yolanda Love, RN</p> <p>Census bed type: SNF/NF: 117 Total: 117</p> <p>Census payor type: Medicare: 32 Medicaid: 67 Other: 18 Total: 117</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed on November 5, 2014, by Janelyn Kulik, RN.</p>	F000000	<p>F000000</p> <p>The facility requests that this plan of correction be considered its credible allegations of compliance.</p> <p>Submission of this response and Plan of Correction is not a legal admission that a deficiency exists or that this statement of deficiency was correctly cited and is also not to be construed as an admission of interest against the facility, the Administrator, or any employee, agents, or other individuals who draft or may be discussed in the response and Plan of Correction. In addition, preparation and submission of the Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the corrections of conclusions set forth in this allegation by the survey agency.</p> <p>Accordingly, the facility has prepared and submitted this Plan of Correction prior to the resolution of appeal of this matter solely because of the requirements under State and Federal law that mandates submission of the Plan of Corrections a condition to participate in the Title 18 and Title 19 programs. The submission of Plan of Correction within this timeframe should in no way be of non-compliance or admission by the facility.</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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F000157 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>November 30, 2014 This facility requests a desk review for paper compliance for this citation.</p>				

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	<p>Based on record review and interview, the facility failed to ensure each resident's Physician was notified in a timely manner following a significant weight loss for 2 of 3 residents reviewed for nutrition of the 10 residents who met the criteria for nutrition. The facility also failed to ensure the Physician was notified of abnormal blood sugar results for 1 of 5 residents reviewed for unnecessary medications. (Residents #47, #112, and #175)</p> <p>Findings include:</p> <p>1. The record for Resident #175 was reviewed on 10/29/14 at 9:00 a.m. The resident's diagnoses included, but was not limited to, dysphagia (difficulty swallowing).</p> <p>Review of the Weight record indicated, the resident weighed 150 pounds on 8/4/14. On 9/10/14, the resident weighed 138 pounds. This was a twelve pound weight loss which was greater than 5% in one month.</p> <p>Review of the Weight Warning note completed by the Registered Dietitian (RD) on 9/10/14, indicated there was no documentation indicating the resident's Physician was notified of the significant</p>	F000157	F157 This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. Resident #175 will have weight loss due to diagnosis. Physician is currently aware of patient status. Resident #112 order is correct with MD aware of current changes. Resident #47 had the blood sugars reviewed with the physician to develop a current notification schedule. Because all residents with the diagnosis of diabetes mellitus, whom receive accu checks are potentially affected by the cited deficiency, on 11/14/14, the director of nursing reviewed the charts, MARs and accu check flow sheets for those residents to ensure that all call orders were being followed, and all were addressed. Because all residents with significant weight changes, whom are weighed in the facility, are potentially affected by the cited deficiency, on 11/14/14, the director of nursing and registered dietician reviewed all weight monitoring reports, and dietary recommendations over the past 30 days, to ensure all were addressed. No other residents were affected. To enhance currently compliant operations	11/30/2014			

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	<p>weight loss.</p> <p>Interview with the Administrator on 10/31/14 at 1:00 p.m., indicated the Physician was currently aware of the resident's weight loss. She did indicate there was no documentation to indicate if the Physician was aware of the resident's significant weight loss in September.</p> <p>2. The record for Resident #112 was reviewed on 10/29/14 at 12:56 p.m. The resident's diagnoses included, but was not limited to, dysphagia (difficulty swallowing).</p> <p>Review of the Weight record, indicated the resident weighed 110 pounds on 9/5/14 and 94 pounds on 10/10/14. A sixteen pound and greater than 5% weight loss in one month.</p> <p>Review of the Weight Warning note completed on 10/15/14 by the Registered Dietitian (RD), indicated a Med Pass nutritional supplement was recommended. There was no documentation indicating the resident's Physician was notified of the significant weight loss and the recommendation for the Med Pass.</p> <p>Interview with the Evening Supervisor on 10/30/14 at 2:10 p.m., indicated there</p>		<p>and under the direction of the director of nurses/designee, on (11/13/14 & 11/14/14) all nursing staff received in-service training regarding state and federal requirements for notification of physician regarding a change in condition. The training emphasized the use of diabetic flow sheets, the weight management policy and procedures, reweight procedures, and dietary recommendations and follow up. All education will include proper and prompt physician notification. Effective (11/14/14), a Performance Improvement program was implemented under the supervision of the director of nurses/designee to monitor residents with diabetes mellitus and significant weight changes, with prompt and proper notification of physician. The director of nurses or designee will perform the following systematic changes: weekly audits for residents with diagnosis of diabetes mellitus who require accu check monitoring with call parameters, and those residents with significant weight changes. Any deficiencies will be corrected on the spot, and the findings of the performance improvement audits will be documented and submitted at the monthly performance improvement committee meeting for further review or corrective action. Completion Date:</p>				

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	<p>was no documentation to indicate if the resident's Physician was notified of the significant weight loss. Further interview on 10/31/14 at 9:34 a.m., indicated the Physician was not notified of the RD recommendation for the Med Pass supplement.</p> <p>Review of the facility's "Notifications" policy provided by the Nurse Consultant on 10/31/14 at 11:30 a.m., and identified as current, indicated the following: "Staff informs the patient, consults with their attending physician, and notifies the patient's surrogates when a significant change occurs in the patient's physical, mental or psychosocial status."</p> <p>3. The record for Resident #47 was reviewed on 10/29/14 at 12:51 p.m. The resident's diagnoses included, but were not limited to, diabetes mellitus type two.</p> <p>Review of Physician Orders dated 7/30/14 indicated to Discontinue the sliding scale insulin and notify the Physician if blood sugar was less than 80 or greater than 250. Continued review of Physician Orders on the 8/2014 recap indicated the resident was to receive an accucheck before meals and at night time.</p> <p>Review of the Diabetic Monitoring Flow Sheet for the month of 8/2014 indicated the resident's blood sugar was greater</p>		<p>11/30/14 November 30, 2014 This facility requests a desk review for paper compliance for this citation.</p>		

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	<p>than 250 on 8/2 at 4:00 p.m., and 8:00 p.m., 8/3 at 4:00 p.m., 8/8 at 11:00 a.m., 4:00 p.m., 8:00 p.m., 8/10 at 7:00 a.m., 4:00 p.m., 8:00 p.m., 8/11 at 7:00 a.m., 4:00 p.m., 8/12 at 7:00 a.m., 8:00 p.m., 8/13 at 7:00 a.m., 11:00 a.m., 8/14 at 8:00 p.m., 8/15 at 4:00 p.m., 8:00 p.m., and 8/17/14 at 4:00 p.m., and 8:00 p.m.</p> <p>Review of Nursing progress notes for the month of 8/2014 indicated there was no evidence of any documentation the Physician was promptly notified of the blood sugars greater than 250 on the above mentioned dates.</p> <p>Review of Physician Orders dated 8/29/14 after the resident had just returned from the hospital indicated accuchecks before meals and notify Physician if blood sugar was less than 60 or greater than 250.</p> <p>Continued review of Physician Orders dated 9/3/14 indicated call Physician if blood sugar over 300 or less than 80.</p> <p>Review of the Diabetic Monitoring Flow Sheet for the month of 9/2014 indicated the resident's blood sugar was greater than 300 on 9/18 at 8:00 p.m.</p> <p>Review of the Diabetic Monitoring Flow Sheet for the month of 10/2014 indicated</p>			

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F000172 SS=D	<p>the resident's blood sugar was greater than 300 on 10/17 at 4:00 p.m., and 10/25 at 4:00 p.m.</p> <p>Review of Nursing progress notes for the months of 9/2014 and 10/2014 indicated there was no evidence of any documentation the Physician was promptly notified of the blood sugars greater than 300 on the above mentioned dates.</p> <p>Interview with the Evening Supervisor on 10/30/14 at 2:20 p.m., indicated the resident's Physician was not notified of the above mentioned blood sugars greater than 250 or 300.</p> <p>3.1-5(a)(3)</p> <p>483.10(j)(1)&(2) RIGHT TO/FACILITY PROVISION OF VISITOR ACCESS The resident has the right and the facility must provide immediate access to any resident by the following:</p> <p>Any representative of the Secretary;</p> <p>Any representative of the State;</p> <p>The resident's individual physician;</p> <p>The State long term care ombudsman (established under section 307 (a)(12) of the</p>			

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	<p>Older Americans Act of 1965);</p> <p>The agency responsible for the protection and advocacy system for developmentally disabled individuals (established under part C of the Developmental Disabilities Assistance and Bill of Rights Act);</p> <p>The agency responsible for the protection and advocacy system for mentally ill individuals (established under the Protection and Advocacy for Mentally Ill Individuals Act);</p> <p>Subject to the resident's right to deny or withdraw consent at any time, immediate family or other relatives of the resident; and</p> <p>Subject to reasonable restrictions and the resident's right to deny or withdraw consent at any time, others who are visiting with the consent of the resident.</p> <p>The facility must provide reasonable access to any resident by any entity or individual that provides health, social, legal, or other services to the resident, subject to the resident's right to deny or withdraw consent at any time.</p> <p>Based on record review and interview, the facility failed to ensure there were no visiting hours restrictions for resident's immediate family members for 1 of 3 residents reviewed for choices of the 10 residents who met the criteria for choices. (Resident #61)</p> <p>Findings include:</p> <p>Interview with Resident #61's spouse on</p>	F000172	<p>F172</p> <p>This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law.</p> <p>It is the policy of this facility that</p>	11/30/2014	

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	<p>10/27/14 at 12:31 p.m., indicated he could not visit his wife before 8:00 a.m., due to the doors being locked. He further indicated he would prefer to visit around 7:30 a.m., but there was no staff available to let him in the facility due to the doors being locked.</p> <p>Review of the Resident Rights provided by the Admission Director on 10/29/14 at 10:20 a.m., indicated the hours of operation provided to family and/or resident at the time of admission indicated the business office was open from 8:00 a.m. to 5:00 p.m., Monday through Friday</p> <p>Further review of the Residents Rights documentation indicated a receptionist was available at our center from 8:00 a.m., to 7:30 p.m., to greet visitors, provide general information about the center, answer the centers phone calls, and deliver the newspaper and mail to our residents. All after hour incoming phone calls to the center were forwarded to the nurses station. The center's main entrance was locked at 8:00 p.m.</p> <p>Interview with the Administrator on 10/29/14 at 10:41 a.m., indicated she was unaware the resident's spouse was not allowed into the facility before 8:00 a.m. She further indicated family members</p>		<p>family may visit a patient 24 hours a day. For resident #61, the family member and resident were notified that he may visit at any time he wishes, and to call ahead if outside of the hours of 8am – 5pm so that someone will be at the front doors to let him in.</p> <p>The nature of the deficiency prohibits the identification of other residents.</p> <p>To enhance currently compliant operations and under the direction of the executive director and director of nurses, on (11/14/14) all nursing staff received in-service training regarding state and federal requirements for right to facility of visitor access. The training emphasized the family of patients being able to visit the resident 24 hours a day, as well as the afterhours visiting procedures.</p> <p>Effective (11/14/14), a Performance Improvement program was implemented under the supervision of the director of nurses to perform random inquiries with families and staff to ensure the knowledge and ability to gain access 24 hours a day to the facility. The director of nurses or designee will perform the following systematic changes: random inquires for families of residents and staff, to ensure the family's ability to visit 24 hours a day. Any deficiencies will be corrected on the spot, and the findings of the performance</p>		

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F000225 SS=D	<p>were allowed 24 hour access at all times. She indicated she tells family members to call before they come so someone was waiting to let them in.</p> <p>3.1-8(a)</p> <p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further</p>		<p>improvement audits will be documented and submitted at the monthly performance improvement committee meeting for further review or corrective action.</p> <p>Completion Date: 11/30/14</p> <p>November 30, 2014 This facility requests a desk review for paper compliance for this citation.</p>		

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	<p>potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>Based on record review and interview, the facility failed to promptly report a resident to resident verbal abuse altercation to the Administrator. The facility also failed to notify the State Agency of an allegation of verbal abuse for 1 of 1 allegations reviewed. (Resident #80)</p> <p>Findings include:</p> <p>Interview with Resident #80's family member on 10/27/14 at 12:30 p.m., indicated there had been an incident this past spring involving another resident. She indicated another resident was taking her things and being verbally abusive, when staff found out about it, they acted quickly to resolve.</p> <p>Review of Resident #80's record on 10/29/14 at 10:25 a.m., indicated her diagnoses included, but were not limited to, dementia, depression and anxiety</p>	F000225	<p>F225</p> <p>This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law.</p> <p>It is the policy of this facility to notify the executive director of any allegations and to make a report to the state agency regarding this allegation. Resident #80 had no negative affect from occurrence. Family member had no concerns as she. Felt everything was acted upon immediately and efficiently.</p> <p>Because all residents are potentially affected by the cited deficiency, on 11/7/14, the executive director and director of nursing with the staff development coordinator educated all staff on the abuse policy, and</p>	11/30/2014			

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	<p>disorder with delusions</p> <p>A Nursing progress note dated 3/19/14 was a late entry for 3/16/14, indicated the resident was seated in hallway when another resident approached and said "move b****". The residents were separated. Resident #80 was assisted into bed.</p> <p>A Social Service progress note dated 3/19/14 indicated she met with the resident's daughter related to the resident to resident incident that occurred on 3/16/14.</p> <p>Interview with the Administrator on 10/31/14 at 8:15 a.m., indicated staff had not reported the above incident to her. She also indicated the facility had not completed an incident report or reported to the State agency. She indicated there had been some staffing changes at that time and the incident had not been reported.</p> <p>3.1-28(c)</p>		<p>reporting of abuse allegations. The Administrator will request the assistance of the Director of Nursing, Social Worker or their designees to assist with investigation of alleged abuse of residents. No other residents were affected.</p> <p>To enhance currently compliant operations and under the direction of the executive director and director of nurses, on (11/04/14) all staff received in-service training regarding facility abuse policy and procedure to include timely notification and has been included in the orientation of new personnel. The performance improvement committee will review any investigation for completeness and make recommendations as necessary to improve the process. This will then be reviewed monthly by the performance improvement committee.</p> <p>Effective (10/21/14), a Performance Improvement program was implemented under the supervision of the executive director and director of nurses to monitor residents with abuse allegations. The director of nurses or designee will perform the following systematic changes: weekly audits for residents with abuse allegations. Any deficiencies will be corrected on the spot, and the findings of the performance improvement audits will be documented and submitted at the monthly performance improvement committee meeting for further review</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155218	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/31/2014
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NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHABILITATION-DYER	STREET ADDRESS, CITY, STATE, ZIP CODE 2300 GREAT LAKES DR DYER, IN 46311
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F000226 SS=D	<p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on record review and interview, the facility failed to follow their Abuse policy regarding promptly reporting a resident to resident verbal abuse altercation to the Administrator and notifying the the State Agency of an allegation of verbal abuse for 1 of 1 allegations reviewed. (Resident #80)</p> <p>Findings include:</p> <p>Interview with Resident #80's family member on 10/27/14 at 12:30 p.m., indicated there had been an incident this past spring involving another resident. She indicated another resident was taking her things and being verbally abusive, when staff found out about it, they acted quickly to resolve.</p>	F000226	<p>or corrective action.</p> <p>Completion Date: 11/30/14</p> <p>November 30, 2014 This facility requests a desk review for paper compliance for this citation.</p> <p>F226</p> <p>This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law.</p> <p>It is the policy of this facility to notify the executive director of any allegations and to make a report to the state agency regarding this allegation. Resident #80 had no negative effects from the identified concern. The family member had no additional concerns.</p> <p>Because all residents are potentially affected by the cited deficiency, on</p>	11/30/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155218		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/31/2014	
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHABILITATION-DYER				STREET ADDRESS, CITY, STATE, ZIP CODE 2300 GREAT LAKES DR DYER, IN 46311			
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	<p>Review of Resident #80's record on 10/29/14 at 10:25 a.m., indicated her diagnoses included, but were not limited to, dementia, depression and anxiety disorder with delusions.</p> <p>A Nursing progress note dated 3/19/14 was a late entry for 3/16/14, indicated the resident was seated in hallway when another resident approached and said "move b****". The residents were separated. Resident #80 was assisted into bed.</p> <p>A Social Service progress note dated 3/19/14 indicated she met with the resident's daughter related to the resident to resident incident that occurred on 3/16/14.</p> <p>Interview with the Administrator on 10/31/14 at 8:15 a.m., indicated staff had not reported the above incident to her. She also indicated the facility had not completed an incident report or reported to State agency. She indicated there had been some staffing changes at that time and the incident had not been reported.</p> <p>The Abuse policy dated 7/28/14 was received from the Administrator on 10/29/14 at 10:25 a.m. The policy indicated prohibitions on abuse applied to</p>		<p>11/7/14, the executive director and director of nursing with the staff development coordinator educated all staff on the abuse policy, and reporting of abuse allegations. The Administrator will request the assistance of the Director of Nursing, Social Worker or their designees to assist with investigation of alleged abuse of residents. No other residents were affected.</p> <p>To enhance currently compliant operations and under the direction of the executive director and director of nurses, on (11/04/14) all staff received in-service training regarding facility abuse policy and procedure to include timely notification and has been included in the orientation of new personnel. The performance improvement committee will review any investigation for completeness and make recommendations as necessary to improve the process. This will then be reviewed monthly by the performance improvement committee.</p> <p>Effective (10/31/14), a Performance Improvement program was implemented under the supervision of the executive director and director of nurses to monitor residents with abuse allegations. The director of nurses or designee will perform the following systematic changes: weekly audits for residents with abuse allegations. Any deficiencies will be corrected on the spot, and the findings of the performance</p>				

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NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHABILITATION-DYER				STREET ADDRESS, CITY, STATE, ZIP CODE 2300 GREAT LAKES DR DYER, IN 46311			
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F000241 SS=D	<p>other patients also. The policy indicated, "The center staff must report all alleged violations involving mistreatment ...immediately to a Senior Clinician, or Operational Leader at the facility, or District, or National Level and to other officials in accordance with State law through established procedures..."</p> <p>3.1-28(a)</p> <p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Based on observation, record review, and interview, the facility failed to ensure each resident's dignity was maintained related to being dressed in a hospital gown for 1 of 4 residents reviewed for dignity of the 4 residents who met the criteria for dignity. (Resident #10)</p> <p>Findings include:</p> <p>On 10/28/14 at 2:20 p.m., and 3:25 p.m., Resident #10 was observed in bed. The resident was dressed in a hospital gown.</p> <p>On 10/29/14 at 8:20 a.m., at 12:49 p.m., and 2:39 p.m., the resident was observed</p>	F000241	<p>improvement audits will be documented and submitted at the monthly performance improvement committee meeting for further review or corrective action.</p> <p>Completion Date: 11/30/14</p> <p>November 30, 2014 This facility requests a desk review for paper compliance for this citation.</p> <p>F241</p> <p>This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law.</p> <p>It is the policy of this facility to provide care with dignity to all residents. The Director of Nursing or designee will counsel and the SDC or designee in-serviced staff members assigned to resident #10 on (11/4/14) and again on (11/13/14)</p>	11/30/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155218	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/31/2014
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHABILITATION-DYER			STREET ADDRESS, CITY, STATE, ZIP CODE 2300 GREAT LAKES DR DYER, IN 46311		
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	<p>in bed wearing a hospital gown.</p> <p>On 10/30/14 at 9:05 a.m., and 10:17 a.m., the resident was observed in bed wearing a hospital gown.</p> <p>Interview with CNA #1 on 10/30/14 at 10:17 a.m., indicated she was taking care of the resident, however, she did not provide morning care this morning. She further indicated the resident did have clothes which included dusters and gowns for her to wear in her closet.</p> <p>Interview with CNA #2 at that time, indicated the Hospice CNA usually comes to the facility early and provides care to the resident.</p> <p>The record for Resident #10 was reviewed on 10/29/14, at 8:50 a.m. The resident was admitted to the facility and at the same time to Hospice on 10/1/14. The resident's diagnoses included, but were not limited to, end of life comfort measures, depression, dementia, and delusions.</p> <p>Review of the Admission Minimum Data Set (MDS) assessment dated 10/8/14 indicated the resident was an extensive assist with one person physical assist for dressing.</p>		<p>and (11/14/14) regarding providing care, with an emphasis on donning clothing daily in a manner that maintains the residents dignity in recognition of her individuality.</p> <p>Because all residents are potentially affected by the cited deficiency, on 11/13/14 & 11/14/14, the director of nursing with the staff development coordinator/designee educated all staff on dressing residents in their clothing daily to provide care with dignity. The Director of Nursing or designee will assess resident's clothing a minimum of twice per week. The Social Service Director or designee will identify through individual interviews as needed those residents who request to wear gowns daily. The care plans of residents that prefer to wear a gown will be updated, as well as any C.N.A. assignment sheets. No other residents were affected.</p> <p>To enhance currently compliant operations and under the direction of the director of nurses or staff development coordinator, on (11/04/14) and again (11/13/14 or 11/14/14) all staff will receive in-service training regarding facility dignity policy and procedure to include providing care with dignity to residents and proper dressing of residents.</p> <p>Effective (11/14/14), The DNS or designee will monitor through observation, record review and</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155218	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/31/2014
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHABILITATION-DYER			STREET ADDRESS, CITY, STATE, ZIP CODE 2300 GREAT LAKES DR DYER, IN 46311		
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F000278 SS=D	<p>Review of the current plan of care dated 10/2014 indicated there was no care plan regarding the resident's preferences to wear hospital gowns.</p> <p>Review of the CNA flow sheet provided by the P.M. Supervisor indicated there was no information the resident preferred to be dressed in a hospital gown.</p> <p>Interview with the P.M. Supervisor on 10/30/14 at 2:20 p.m., indicated there was no reason the resident was dressed in a hospital gown and not in regular clothes.</p> <p>3.1-3(t)</p> <p>483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status.</p> <p>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health</p>		<p>resident interview to assure that residents receive services and care to maintain their dignity. The Administrator will review concern/grievance reports and provide appropriate follow through. This will be done through a Performance Improvement program was implemented under the supervision of the director of nurses to monitor residents with dignity concerns. The director of nurses or designee will perform the following systematic changes: twice weekly observations for residents with gowns worn during the day. Any deficiencies will be corrected on the spot, and the findings of the performance improvement audits will be documented and submitted at the monthly performance improvement committee meeting for further review or corrective action.</p> <p>Completion Date: 11/30/14</p> <p>November 30, 2014 This facility requests a desk review for paper compliance for this citation.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155218	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/31/2014
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NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHABILITATION-DYER	STREET ADDRESS, CITY, STATE, ZIP CODE 2300 GREAT LAKES DR DYER, IN 46311
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	<p>professionals.</p> <p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>Based on record review and interview, the facility failed to ensure each resident's comprehensive assessment was accurate related to antianxiety medications for 1 of 5 resident's reviewed for unnecessary medications of the 5 residents who met the criteria for unnecessary medications. (Resident #47)</p> <p>Findings include:</p> <p>The record for Resident #47 was reviewed on 10/20/14 at 12:51 p.m. The resident's diagnoses included, but were not limited to, anxiety.</p>	F000278	<p>F278</p> <p>This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law.</p> <p>The MDS for Resident #47 has been corrected. A corrected MDS has been transmitted.</p> <p>The Interdisciplinary Team will review the most current MDS for each resident on anti-anxiety to</p>	11/30/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155218	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/31/2014
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHABILITATION-DYER			STREET ADDRESS, CITY, STATE, ZIP CODE 2300 GREAT LAKES DR DYER, IN 46311		
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	<p>Review of the Quarterly Minimum Data Set (MDS) assessment dated 9/30/14 indicated the resident's Brief Interview for Mental Status (BIMS) was a 15, indicating she was alert and oriented. Under the section Medications, it indicated the resident received 7 days of an antipsychotic medication, 0 days of an antianxiety medication, and 7 days of an antidepressant medication.</p> <p>Review of the previous Quarterly MDS assessment dated 7/3/14 indicated under the medication section a "0" was coded for antianxiety medications for the number of times the resident received the medication in the last 7 days.</p> <p>Review of the 7/2014 and the 9/2014 Physician Order Statement indicated the resident was receiving Buspar (an antianxiety medication) 15 milligrams twice a day.</p> <p>Interview with MDS Coordinator #1 on 10/31/14, at 10:00 a.m., indicated the other MDS Coordinator signs and completes all of the MDS assessments because she was the RN. However, she further indicated she had probably made the mistake on the 9/2014 Quarterly assessment because she always gets confused of what classification Buspar</p>		<p>assess it for accuracy and correct any information determined to be inaccurate.</p> <p>On (11/5/14) the District Director of Case Management in-serviced the Interdisciplinary Team on the accuracy of the information coded on each MDS. This focused on the attestation statement of the MDS. The Interdisciplinary Team members will verify the accuracy of the coded information on each MDS prior to affixing their signatures.</p> <p>The RN MDS Coordinator or designee will monitor through observation and record review the accuracy of the MDS. The auditing will be reviewed and analyzed monthly for three months and then quarterly at the performance improvement meeting with a subsequent plan of action developed and implemented as indicated. The Administrator is responsible for the overall compliance.</p> <p>Completion Date: 11/30/14</p> <p>November 30, 2014 This facility requests a desk review for paper compliance for this citation.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155218		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/31/2014	
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHABILITATION-DYER				STREET ADDRESS, CITY, STATE, ZIP CODE 2300 GREAT LAKES DR DYER, IN 46311			
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F000282 SS=D	<p>was in.</p> <p>3.1-31(i)</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on observation, record review, and interview, the facility failed to ensure the resident's plan of care and/or Physician Orders were followed related to providing nutritional supplements and blood glucose monitoring for 2 of 5 residents reviewed for unnecessary medications of the 5 residents who met the criteria for unnecessary medications. (Residents #42 and #47)</p> <p>Findings include:</p> <p>1. The record for Resident #47 was reviewed on 10/29/14 at 12:51 p.m. The resident's diagnoses included, but were not limited to, diabetes mellitus type two.</p> <p>Review of Physician Orders dated 7/30/14 indicated to Discontinue the sliding scale insulin and notify the Physician if blood sugar was less than 80 or greater than 250. Continued review of Physician Orders on the 8/2014 recap</p>	F000282	<p>F282</p> <p>This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law.</p> <p>It is the policy of this facility to provide care according to the physician orders and document per facility policy. For resident #47 and #42 the physicians were notified. No new orders were received. Current staff caring for these residents were counseled and educated regarding the documentation policy and following physician orders.</p> <p>Because all residents within the facility are potentially affected by the cited deficiency, on 11/14/14, the director of nursing reviewed the MARs to ensure that all call orders</p>	11/30/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155218	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/31/2014
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHABILITATION-DYER			STREET ADDRESS, CITY, STATE, ZIP CODE 2300 GREAT LAKES DR DYER, IN 46311		
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	<p>indicated the resident was to receive an Accucheck before meals and at night time.</p> <p>Review of the Diabetic Monitoring Flow Sheet for the months of 8/2014, 9/2014, and 10/2014 indicated there was no blood glucose obtained on the following dates: 8/1 at 7:00 a.m., 11:00 a.m., 8/7 at 11:00 a.m., 9/3 at 11:00 a.m., 9/7 at 4:00 p.m., 8:00 p.m., 9/22 at 11:00 a.m., 9/25 at 11:00 a.m., 10/7 at 7:00 a.m., 10/14 at 4:00 p.m., and 10/26/14 at 7:00 a.m., and 11:00 a.m.</p> <p>Interview with the P.M. Supervisor on 10/30/14 at 2:20 p.m., indicated the nurses were to document the blood glucose results on the Diabetic Monitoring Flow Sheet. She further indicated if they were not documented on that form or in Nurse's Notes then she could not confirm they were completed.</p> <p>2. The record for Resident #42 was reviewed on 10/29/14 at 10:49 a.m. The resident's diagnoses included, but were not limited to, dementia, depression, alerted mental status, muscle weakness, falls, and hallucinations.</p> <p>Review of the Physician's Order Statement for 9/2014 indicated one carton Boost Plus (a nutritional supplement) twice a day.</p>		<p>were being followed, and all were addressed. Monitoring has been put into place to ensure proper documentation per physician orders and facility policy are occurring during morning clinical meetings.</p> <p>To enhance currently compliant operations and under the direction of the director of nurses, on (11/14/14) all nursing staff received in-service training regarding state and federal requirements for following of physician orders and the facility documentation policy.</p> <p>Effective (11/14/14), a Performance Improvement program was implemented under the supervision of the director of nurses to monitor all residents within the facility daily for following physician orders with proper documentation per facility policy. The director of nurses or designee will perform the following systematic changes: daily audits of MARs and TARs for each resident within the facility. Any deficiencies will be corrected on the spot, and the findings of the performance improvement audits will be documented and submitted at the monthly performance improvement committee meeting for further review or corrective action.</p> <p>Completion Date: 11/30/14</p> <p>November 30, 2014 This facility requests a desk review for paper compliance for this citation.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155218	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/31/2014
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NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHABILITATION-DYER	STREET ADDRESS, CITY, STATE, ZIP CODE 2300 GREAT LAKES DR DYER, IN 46311
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	<p>Review of the Medication Administration Record (MAR) dated 8/2014 indicated on 8/2/14 through 8/4/14 at 10:00 a.m. and 3:00 p.m., the resident did not receive her nutritional supplement as ordered. On 8/7/14 at 10:00 a.m. and 3:00 p.m. the resident did not receive her nutritional supplement as ordered. On 8/20/14 at 10:00 a.m. and 3:00 p.m. the resident did not receive her nutritional supplement as ordered. On 8/25/14 and 8/26/14 at 3:00 p.m. the resident did not receive her nutritional supplement as ordered. On 8/28/14 at 10:00 a.m., and 3:00 p.m. the resident did not receive her nutritional supplement as ordered. On 8/29/14, 8/30/14 and 8/31/14 the resident did not receive her 3:00 p.m. nutritional supplement as ordered. On 9/26/2014 at 10:00 a.m., and 3:00 p.m., the resident did not receive her nutritional supplement as ordered. And on 9/27/14 at 3:00 p.m. through 9/30/14, the resident did not receive her nutritional supplement as ordered.</p> <p>Review of the care plan dated 6/26/12, and revised on 9/30/2014, indicated Nutritional risk related to mechanically altered diet, dependence on others for feeding and dementia. The goals included, but were not limited to, will consume 75% of Boost Plus twice a day.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155218		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/31/2014	
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHABILITATION-DYER				STREET ADDRESS, CITY, STATE, ZIP CODE 2300 GREAT LAKES DR DYER, IN 46311			
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F000318 SS=D	<p>The interventions also included, but were not limited to, provide Boost Plus twice a day.</p> <p>Interview with LPN #1 on 10/29/2014 at 11:20 a.m., indicated the resident should have been given her nutritional supplement as ordered.</p> <p>3.1-35(g)(2)</p> <p>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. Based on observation, record review and interview, the facility failed to ensure a resident received appropriate treatment to prevent further decrease in range of motion related to not applying a splint to a resident with contractures as recommended for 1 of 4 resident's reviewed for range of motion. (Resident #101).</p> <p>Findings include:</p> <p>On 10/28/14 at 2:45 p.m., 10/29/14 at 8:30 a.m. and 11:17 a.m., Resident #101 was observed to be up in her wheelchair.</p>	F000318	F318 This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. It is the policy of this facility to provide care to prevent the decrease in range of motion to residents. For resident #101 a physician orders or occupational therapy was given. OT evaluation completed prior to survey	11/30/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155218	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/31/2014
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	<p>Her hands were noticeably contracted, (in a fixed position) and she was not wearing a splinting device or palm protectors.</p> <p>The resident's record was reviewed on 10/29/14 at 10:04 a.m. . The resident's diagnoses included, but were not limited to, diabetes, heart disease and unspecified psychosis.</p> <p>The Quarterly Minimum Data Set (MDS) assessment dated 9/25/14 indicated the resident required extensive two person assistance for transferring and was completely dependent on dressing. The resident's Brief Interview for Mental Status (BIMS) score was 12, which indicated some cognitive impairment.</p> <p>A care plan dated 1/12/14 indicated the resident had actual impairment related to not able to achieve full functional range of motion in both hand. The goal was to remain free of complications related to impaired range of motion. Interventions included, but were not limited to, refer to therapy as necessary.</p> <p>An Occupational Therapy (OT) Progress and Discharge Summary dated 8/10/14, indicated the resident was referred to OT on 6/10/14 for treatment of joint contractures. She was discharged from</p>		<p>exit with findings discussed. Resident continues on therapy. Resident #42 the physicians were notified. No new orders received.</p> <p>Because all residents with a potential for decline with range of motion after discharge from occupational therapy are potentially affected by the cited deficiency, on 11/7/14, the director of nursing reviewed all occupational therapy discharges within the past 90 days to ensure that splinting and range of motion nursing programs were carried out per recommendations. All residents were addressed. Monthly audits have been put into place to assess current nursing program. Therapy and nursing communication form started to ensure proper start of any therapy recommended nursing program. All orders, care plans, and assignment sheets have been audited and updated.</p> <p>To enhance currently compliant operations and under the direction of the director of nurses, on (11/13/14 & 11/14/14) all nursing staff received in-service training regarding state and federal requirements for range of motion. This training will focus on the new procedure with therapy communication of rehab recommendations for nursing programs, as well as conducting the programs of splinting by the nursing staff.</p> <p>Effective 11/14/14, a Performance</p>		

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	<p>OT on 8/10/14. The progress note related to Splinting indicated, "The patient will tolerate BUE (bilateral upper extremities) for 45 minutes, with application of functional position splint in order to prevent contractures." The Patient /Caregiver Training portion indicated, "...both hands splinting program and follow through wearing schedule."</p> <p>Interview with OT Aide #1 on 10/29/13 at 2:13 p.m., indicated when the resident was discharged from OT on 8/10/14 her care was transferred to Restorative Nursing. She was to receive range of motion and splint application to both hands.</p> <p>Interview with the MDS Nurse, who was in charge of Restorative program, on 10/29/13 at 3:00 p.m., indicated the resident had been discharged from Restorative Nursing on 9/24/14, because she was receiving Physical Therapy services. It was believed she could not have Restorative services for her upper extremities while receiving Physical Therapy.</p> <p>Interview with the Director of Nursing on 10/29/14 at 3:15 p.m., indicated Nursing staff could apply splints for contracture management if the resident was not on the Restorative Nursing program. She</p>		<p>Improvement program was implemented under the supervision of the director of nurses to monitor all residents with a potential for decline in range of motion monthly. The director of nurses or designee will perform the following systematic changes: monthly audits of residents with a potential decline in range of motion to ensure proper programs are in place. Any deficiencies will be corrected on the spot, and the findings of the performance improvement audits will be documented and submitted at the monthly performance improvement committee meeting for further review or corrective action.</p> <p>Completion Date: 11/30/14</p> <p>November 30, 2014 This facility requests a desk review for paper compliance for this citation.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155218	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/31/2014
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F000325 SS=D	<p>indicated there was not a current Physician order for Resident #101 to wear splints.</p> <p>3.1-42(a)(2)</p> <p>483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. Based on record review and interview, the facility failed to ensure acceptable parameters of nutrition were maintained related to implementing Registered Dietitian (RD) recommendations after a significant weight loss for 1 of 3 residents reviewed for nutrition of the 10 residents who met the criteria for nutrition. (Resident #112)</p> <p>Findings include:</p> <p>The record for Resident #112 was reviewed on 10/29/14 at 12:56 p.m. The resident's diagnoses included, but was not limited to, dysphagia (difficulty swallowing).</p>	F000325	<p>F325</p> <p>This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law.</p> <p>It is the policy of this facility to provide care to prevent weight loss of residents if avoidable. The nursing staff and the Interdisciplinary Care Planning Team reassessed resident #112 and an individualized plan of care has been developed to address the nutritional needs of each</p>	11/30/2014	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155218	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/31/2014
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NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHABILITATION-DYER	STREET ADDRESS, CITY, STATE, ZIP CODE 2300 GREAT LAKES DR DYER, IN 46311
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	<p>Review of the Weight record, indicated the resident weighed 110 pounds on 9/5/14 and 94 pounds on 10/10/14. A sixteen pound and greater than 5% weight loss in one month.</p> <p>On 10/15/14 at 3:26 p.m., a Weight Warning note was completed by the Registered Dietitian (RD). The note indicated the resident weighed 93.8 pounds on 10/10/14. Greater than 5% weight loss in 30 days. Monthly weight reflects loss although prior weights stable. BMI (body mass index) now in underweight range. Resident does show variable meal intakes. Offered double portions. Suggest to add Med Pass (a nutritional supplement) and continue weekly weights.</p> <p>Continued review of the Nursing progress notes for the month of October 2014, indicated there was no documentation to indicate if the Physician had been notified of the significant weight loss and the RD recommendation for Med Pass.</p> <p>Review of the Physician's orders for the month of October 2014, indicated there was no order for Med Pass.</p> <p>Interview with the Evening Supervisor on</p>		<p>resident. The dietary recommendation was completed and order received.</p> <p>Because all residents with a potential for weight loss with dietary recommendations are potentially affected by the cited deficiency, on 11/7/14, the Director of Nursing, registered dietician, and the Interdisciplinary Care Planning Team reassessed each resident with weight loss and an individualized plan of care was developed to address the nutritional needs of those residents identified in need. Monthly audits and weight reports have been put into place. All orders, care plans, and assignment sheets have been audited and updated.</p> <p>To enhance currently compliant operations and under the direction of the director of nurses, on 11/14/14 all nursing staff received in-service training regarding state and federal requirements for prevention of weight loss in residents. This training focused on the weight monitoring policy and procedure, as well as the dietary recommendations policy and procedure, the documentation of meal intake and supplement consumption, providing feeding assistance, offering substitutes and reporting requirements. The Administrator, Director of Nursing, Dietary Manager, and Regional Consultants reviewed the facility's Weight Monitoring Policy and Procedure on</p>	

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	<p>10/30/14 at 2:10 p.m., indicated there was no documentation to indicate if the resident's Physician was notified of the significant weight loss. She also indicated that she would have to check with the Director of Nursing to see if she had received any recommendations from the RD for the resident.</p> <p>Interview with the Evening Supervisor on 10/31/14 at 9:34 a.m., indicated the RD recommendation was not carried out for the Med Pass and there was no documentation to indicate if the resident's Physician was notified of the significant weight loss.</p> <p>3.1-46(a)(1)</p>		<p>11/5/14. The Director of Nursing, or her designee, in-serviced the staff on the Weight Monitoring Policy and Procedure, documentation of meal intake and supplement consumption, providing feeding assistance, offering substitutes and reporting requirements. The Director of Nursing, or her designee, will conduct at least weekly meal rounds to observe feeding assistance and meal consumption, with individualized interventions as identified.</p> <p>Effective 11/14/14, a Performance Improvement program was implemented under the supervision of the director of nurses to monitor all residents with a potential for weight loss with dietary recommendations. The following systemic changes: the director of nurses or designee will perform through direct observation, and record review, at least monthly for three months, then at least quarterly, that the facility maintains the nutritional needs of the residents. The Administrator is responsible for overall compliance. Any deficiencies will be corrected on the spot, and the findings of the performance improvement audits will be documented and submitted at the monthly performance improvement committee meeting for further review or corrective action.</p> <p>Completion Date: 11/30/14</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155218	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/31/2014
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F000329 SS=D	<p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 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 record review and interview, the facility failed to ensure each resident's drug regimen was free from unnecessary drugs related to the indication for the use of an antianxiety medication, monitoring the use of an anticoagulant, and ensuring gradual dose reductions were completed for antianxiety medications for 3 of 5</p>	F000329	<p>November 30, 2014 This facility requests a desk review for paper compliance for this citation.</p> <p>F329 This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by</p>	11/30/2014

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	<p>residents reviewed for unnecessary medications. (Residents #5, #35, and #47)</p> <p>Findings include:</p> <p>1. The record for Resident #5 was reviewed on 10/28/14 at 2:20 p.m. The resident's diagnoses included, but were not limited to, sleep apnea, atrial fibrillation, and dementia without behavior disturbance.</p> <p>A Physician's order dated 10/13/14, indicated the resident was to receive Xanax (an antianxiety medication) 0.25 milligrams (mg) every night for insomnia. Review of the Nursing progress notes for the month of October 2014, indicated there were no documented episodes of insomnia.</p> <p>Interview with the Evening Supervisor on 10/29/14 at 2:00 p.m., indicated there were no documented episodes of insomnia and Xanax was an antianxiety medication and she was not sure why it was prescribed for insomnia.</p> <p>A Physician's order dated 9/2/14, indicated the resident was to receive Coumadin (a blood thinner) 6 mg daily. The resident's PT/INR (a blood clotting study) was to be completed in one week.</p>		<p>state and federal law.</p> <p>It is the policy of this facility to provide care to ensure that the drug regimen of each patient is free of unnecessary drugs. The nursing staff and the Interdisciplinary Care Planning Team reassessed resident #5, #35, and #47 and an individualized plan of care has been developed to address the psychosocial needs of each resident. A behavior meeting was conducted on 11/06/14. The physician was notified of the recommendations of the behavior committee review.</p> <p>Because all residents taking a psychotropic medication are potentially affected by the cited deficiency, on 11/6/14, the Director of Nursing, and interdisciplinary team reassessed residents during a behavioral meeting with psychotropic medications and an individualized plan of care was developed to address the psychosocial needs of those residents identified. Monthly meetings have been put into place. All orders, care plans, and assignment sheets will continue to be audited and updated.</p> <p>To enhance currently compliant operations and under the direction of the director of nurses, on 11/13/14 & 11/14/14 all nursing staff received in-service training regarding state and federal requirements. This training will focus on the</p>		

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NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHABILITATION-DYER	STREET ADDRESS, CITY, STATE, ZIP CODE 2300 GREAT LAKES DR DYER, IN 46311
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	<p>On 9/9/14, the resident's PT (prothrombin time) was 25.4. The Physician was aware and an order was written on the laboratory result sheet for "Continue Coumadin 6 mg, PT/INR in one week."</p> <p>A Physician's order dated 9/29/14, indicated the resident's Coumadin was to be discontinued and a STAT (immediate) PT/INR was to be completed and the Physician was to be called with the results.</p> <p>Review of the laboratory results indicated there was no PT/INR collected between 9/9 and 9/29/14. The resident's PT/INR on 9/29/14 was high at 33.3. The Physician was notified and orders were received to continue the current dose of Coumadin and get a PT/INR in one week.</p> <p>Interview with the Evening Supervisor on 10/31/14 at 9:34 a.m., indicated the resident's PT/INR was not monitored as ordered between 9/9 and 9/29/14.</p> <p>2. The record for Resident #47 was reviewed on 10/29/14, at 12:51 p.m. The resident's diagnoses included, but were not limited to, anxiety, dementia without behaviors, convulsions, and bipolar disorder.</p> <p>Review of the Quarterly Minimum Data</p>		<p>psychotropic medication side effects as well as the behavior management program. Behavior management meeting are in place monthly. All residents taking psychotropic medications have been reviewed. The social services director or her designee, and the director of nursing services, will conduct monthly audits to observe GDR reviews as needed, and pharmacy recommendation follow up of psychotropic medications by the physician.</p> <p>Effective 11/14/14, a Performance Improvement program was implemented under the supervision of the director of nurses to monitor all residents with psychotropic medications. The following systemic changes: the social services director or designee will perform audits monthly to ensure follow up of GDRs as needed, as well as pharmacy recommendations follow up by physician. The Administrator is responsible for overall compliance. Any deficiencies will be corrected on the spot, and the findings of the performance improvement audits will be documented and submitted at the monthly performance improvement committee meeting for further review or corrective action.</p> <p>Completion Date: 11/30/14</p> <p>November 30, 2014 This facility requests a desk review for paper compliance for this citation.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155218	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/31/2014
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NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHABILITATION-DYER	STREET ADDRESS, CITY, STATE, ZIP CODE 2300 GREAT LAKES DR DYER, IN 46311
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	<p>Set (MDS) assessment dated 9/30/14 indicated the resident was alert and oriented with a Brief Interview for Mental Status (BIMS) score of 15. The resident had no mood or behavior problems during the resident interview. The resident was coded as receiving in the last 7 days, insulin, an antipsychotic medication, and an antidepressant medication.</p> <p>Review of Physician Orders on the current 10/2014 recap indicated the following: Risperdal (an antipsychotic medication) .5 milligrams (mg) daily, Buspar (an antianxiety medication) 15 mg twice a day, Depakote (a mood stabilizer) 500 mg at night time, Depakote 250 mg at 8:00 a.m., and Celexa (an antidepressant medication) 10 mg daily.</p> <p>Review of the 4/24/13 admission Physician Orders indicated the resident was admitted with Risperdal .5 mg three times a day, Buspar 15 mg twice a day, and Celexa 10 mg daily.</p> <p>Interview with Social Service Director on 10/30/14 7:22 a.m., indicated the resident had been receiving Psychiatric services in the community over the last 25 years prior to entering the facility.</p>			

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	<p>Review of the Psychiatric Progress Note dated 5/22/14 indicated "Pt. (patient) known to psych services history of anxiety. Per staff pt. remains anxious. Per pt. 'I have always been anxious.' Stable. No acute distress." The assessment and treatment plan indicated to reject a GDR of Depakote and Buspar. The reduction may interfere with stability.</p> <p>Review of the Nursing Progress Notes for the months of 4/2014 and 5/2014 indicated there was no evidence of any documentation the resident had any anxious behavior.</p> <p>Review of Social Service Progress Notes for the months of 3/2014, 4/2014, and 5/2014 indicated there was no evidence of any anxious behavior displayed by the resident.</p> <p>Review of the behavior logs for the above mentioned months completed by the CNAs indicated there was no documentation the resident was having any anxious behavior.</p> <p>Review of the Psychiatric Progress Note dated 9/4/14 indicated "Pt. (patient) known to psych services history of anxiety. Per staff no Hallucinations or delusions reported or observed. Good</p>						

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	<p>cognition. Stable at this time." The assessment and treatment plan indicated will reject a GDR for Buspar, Celexa, and Risperdal at this time. May interfere with stability of patient.</p> <p>Review of Nurses Notes for months of 6/14, 7/14, 8/14, and 9/14 indicated there was no evidence of any documented behaviors of anxiety or depression.</p> <p>Review of Social Service Progress Notes for the months of 6/2014, 7/2014, 8/2014, and 9/2014 indicated there was no evidence of any anxious or depressive behavior displayed by the resident.</p> <p>Review of the behavior logs for the above mentioned months completed by the CNAs indicated there was no documentation the resident was having any anxious or depressive behavior.</p> <p>Interview with Social Service Director on 10/30/14 at 9:42 a.m., indicated the Buspar had not had a Gradual Dose Reduction since the resident had resided at the facility. She further indicated the GDR had always been contraindicated by the Psych services Nurse Practitioner.</p> <p>3. The record for Resident #35 was reviewed on 10/29/14 at 10:17 a.m. The resident's diagnoses included, but was not limited to, depression and dementia with</p>			

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	<p>psychosis.</p> <p>The Quarterly Minimum Data Set assessment dated 9/30/14, indicated the resident's Brief Interview for Mental Status (BIMS) score was 8, which indicated she had some cognitive impairment.</p> <p>The October 2014 Physician Order Statement indicated the resident received Ativan (an anti-anxiety medication) 1 milligram (mg) every 12 hours since ordered on 5/13/13.</p> <p>A care plan dated 6/25/12 indicated the resident used anti-anxiety medication related to anxiety disorder. Interventions included to consult with Physician placing resident on dose reduction program and to review with Interdisciplinary team for gradual dose reductions (GDR) as indicated.</p> <p>A Pharmacy Consultation Report was completed on 5/8/14. There was a recommendation to decrease the Ativan from 1 mg to .5 mg every 12 hours. There was no response from the Physician.</p> <p>A Pharmacy Consultation Report was completed on 9/11/14. The recommendation was made again to</p>			

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NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHABILITATION-DYER				STREET ADDRESS, CITY, STATE, ZIP CODE 2300 GREAT LAKES DR DYER, IN 46311			
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F000428 SS=D	<p>decrease the Ativan from 1 mg to .5 mg every 12 hours. The recommendation was declined and signed by the Physician on 10/29/14.</p> <p>Interview with Social Service Director on 10/30/14 at 11:00 a.m., indicated there was no additional information related to the GDR of Ativan. There was not an attempt or Physician statement declining a GDR since 5/13/13.</p> <p>3.1-48(b)(1)</p> <p>483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.</p> <p>The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.</p> <p>Based on record review and interview, the facility failed to ensure pharmacy recommendations were followed and carried out in a timely manner related to monitoring of labs and a Gradual Dose Reduction (GDR) for an antianxiety</p>	F000428	F428 This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly.	11/30/2014			

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	<p>medication for 2 of 5 residents reviewed for unnecessary medications of the 5 residents who met the criteria for unnecessary medications. (Residents #35 and #47)</p> <p>Findings include:</p> <p>1. The record for Resident #47 was reviewed on 10/29/14, at 12:51 p.m. The resident's diagnoses included, but were not limited to, diabetes mellitus type two, high blood pressure, obesity, and stroke.</p> <p>Review of a pharmacy consultation report dated 8/1-8/30/14 indicated the resident was receiving atorvastatin calcium (Lipitor) (a medication used to lower cholesterol) and did not have a fasting lipid profile documented in the last 12 months. The recommendation was to consider a fasting lipid panel on the next convenient lab day and annually thereafter. The report had not been signed or dated with any kind of response by the Physician.</p> <p>Review of pharmacy consultation dated 10/2014 indicated the resident was receiving atorvastatin calcium (Lipitor) and did not have a fasting lipid profile documented in the last 12 months. The recommendation was to please respond promptly for fasting lipid panel on the</p>		<p>This Plan of Correction is submitted to meet requirements established by state and federal law.</p> <p>It is the policy of this facility to ensure follow through on the drug regimen reviews. For resident #47 the pharmacy recommendation was signed, the lipid panel was obtained. For resident #35 the physician was notified of pharmacy recommendation, ativan was deemed necessary by the psychiatric nurse practitioner. Resident #35 was also reviewed 10/21/14 by Social Services with the family who now has requested med management by the nurse practitioner.</p> <p>Because all residents obtaining pharmacy medication regimen reviews are potentially affected by the cited deficiency, on 11/7/14, the Director of Nursing reviewed the pharmacy recommendations in the past 30 days and provided any follow up needed to the physician and pharmacy. A behavior management meeting was held for residents identified for the need on 11/06/14. Monthly meetings have been put into place. All orders and care plans have been audited and updated.</p> <p>To enhance currently compliant operations and under the direction of the director of nurses, on 11/13/14 & 11/14/14 all nursing staff received in-service training. This training focused on the psychotropic medication side effects as well as the</p>		

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	<p>next convenient lab day . The recommendation was signed and dated by the Physician on 10/22/14.</p> <p>Interview with the P.M. Supervisor on 10/30/14 at 2:20 p.m., indicated the pharmacy recommendation was not acted upon in August 2014 when the lipid panel was first recommended.</p> <p>2. The record for Resident #35 was reviewed on 10/29/14 at 10:17 a.m. The resident's diagnoses included, but was not limited to, depression and dementia with psychosis.</p> <p>The Quarterly Minimum Data Set assessment dated 9/30/14, indicated the resident's Brief Interview for Mental Status (BIMS) score was 8, which indicated she had some cognitive impairment.</p> <p>The October 2014 Physician Order Statement indicated the resident received Ativan (an anti-anxiety medication) 1 milligram (mg) every 12 hours since ordered on 5/13/13.</p> <p>A care plan dated 6/25/12 indicated the resident used anti-anxiety medication related to anxiety disorder. Interventions included to consult with Physician placing resident on dose reduction program and to review with</p>		<p>behavior management program. Behavior management meeting are in place monthly. All residents taking psychotropic medications have been reviewed. The social services director or of her designee, and the director of nursing services, will conduct monthly audits to observe GDR reviews as needed, and pharmacy recommendation follow up of psychotropic medications by the physician.</p> <p>Effective 11/14/14, a Performance Improvement program was implemented under the supervision of the director of nurses to monitor all residents pharmacy recommendations. The following systemic changes: the director of nursing services or designee will perform audits monthly to ensure follow up of all pharmacy recommendations. The Administrator is responsible for overall compliance. Any deficiencies will be corrected on the spot, and the findings of the performance improvement audits will be documented and submitted at the monthly performance improvement committee meeting for further review or corrective action.</p> <p>Completion Date: 11/30/14</p> <p>November 30, 2014 This facility requests a desk review for paper compliance for this citation.</p>	

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F000520 SS=D	<p>Interdisciplinary team for gradual dose reductions (GDR) as indicated.</p> <p>A Pharmacy Consultation Report was completed on 5/8/14. There was a recommendation to decrease the Ativan from 1 mg to .5 mg every 12 hours. There was no response from the Physician.</p> <p>A Pharmacy Consultation Report was completed on 9/11/14. The recommendation was made again to decrease the Ativan from 1 mg to .5 mg every 12 hours. The recommendation was declined and signed by the Physician on 10/29/14.</p> <p>Interview with Social Service Director on 10/30/14 at 11:00 a.m., indicated there was no additional information related to the GDR of Ativan. There was not an attempt or Physician statement declining a GDR since 5/13/13.</p> <p>3.1-25(j)</p> <p>483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS</p> <p>A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.</p>						

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	<p>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. Based on interview and record review, the facility failed to identify the non-compliance of splint application when a resident was discharged from Occupational Therapy through the facility's quality assurance protocol. (Resident #101)</p> <p>Findings include:</p> <p>Interview with the Administrator on 10/31/14 at 12:30 p.m., indicated the Quality Assessment and Assurance (QA & A) committee consisted of herself, the Director of Nursing, department heads as needed, the Medical Director and consulting Pharmacist. She indicated the committee met monthly. She indicated the QA & A committee had addressed</p>	F000520	<p>F520</p> <p>This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law.</p> <p>The Executive Director will review the Performance Improvement schedule with the Medical Director.</p> <p>The facility will retain an accurate Record of attendance of all required and elective attendants to the Performance Improvement meetings.</p> <p>The Medical Director will continue to receive an annual schedule of the</p>	11/30/2014

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	<p>concerns related to providing Restorative services to residents discharged from Occupational or Physical Therapy last month. She also indicated splint applications were removed from the Restorative program. She indicated the use of splints should have been on the monthly recap, which was reviewed at the end of each month as a "failsafe". Recaps were last completed at the end of September and splints were not on this residents recap. A facility audit had been completed on 10/29/14 to identify residents discharged from therapy who were not receiving splinting as recommended.</p> <p>On 10/28/14 at 2:45 p.m., 10/29/14 at 8:30 a.m. and 11:17 a.m., Resident #101 was observed to be up in her wheelchair. Her hands were noticeably contracted, she was not wearing a splinting device or palm protectors.</p> <p>The resident's record was reviewed on 10/29/14 at 10:04 a.m. . The resident's diagnoses included, but were not limited to, diabetes, heart disease and unspecified psychosis.</p> <p>The Quarterly Minimum Data Set (MDS) assessment dated 9/25/14 indicated the resident required extensive two person assistance for transferring and was</p>		<p>quarterly Performance Improvement Committee meetings. Additionally, the facility will contact his or her office one-week before the meetings to confirm attendance. If there is a schedule conflict rendering the Medical Director unable to attend, the quarterly meeting will be rescheduled to a date when he or she is available. All audit sheets, and performance improvement plans will be reviewed as required. All minutes will be filed with monthly reviews.</p> <p>Completion Date: 11/30/14</p> <p>November 30, 2014 This facility requests a desk review for paper compliance for this citation.</p>				

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	<p>completely dependent on dressing. The resident's BIMS (brief interview for mental status) score was 12, which indicated some cognitive impairment.</p> <p>A care plan dated 1/12/14 indicated the resident had actual impairment related to not able to achieve full functional range of motion in both hand. The goal was to remain free of complications related to impaired range of motion. Interventions included, but were not limited to, refer to therapy as necessary.</p> <p>An Occupational Therapy (OT) Progress and Discharge Summary dated 8/10/14, indicated the resident was referred to OT on 6/10/14 for treatment of joint contractures. She was discharged from OT on 8/10/14. The progress note related to Splinting indicated, "The patient will tolerate BUE (bilateral upper extremities) for 45 minutes, with application of functional position splint in order to prevent contractures." The Patient /Caregiver Training portion indicated, "...both hands splinting program and follow through wearing schedule."</p> <p>Interview with OT Aide #1 on 10/29/13 at 2:13 p.m., indicated when the resident was discharged from OT on 8/10/14 her care was transferred to Restorative Nursing. She was to receive range of</p>			

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	<p>motion and splint application to both hands.</p> <p>Interview with the MDS Nurse, who was in charge of Restorative program, on 10/29/13 at 3:00 p.m., indicated the resident had been discharged from Restorative Nursing on 9/24/14, because she was receiving Physical Therapy services. It was believed she could not have Restorative services for her upper extremities while receiving Physical Therapy.</p> <p>Interview with the Director of Nursing on 10/29/14 at 3:15 p.m., indicated Nursing staff could apply splints for contracture management if the resident was not on the Restorative Nursing program. She indicated there was not a current Physician order for Resident #101 to wear splints.</p> <p>3.1-52(b)(2)</p>				