

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155115	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/09/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER CARDINAL NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1121 E LASALLE AVE SOUTH BEND, IN 46617
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F000000	<p>This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint #IN00159556</p> <p>Complaint #IN00159556 - Substantiated. No deficiencies related to the allegations are cited.</p> <p>Survey dates: December 2, 3, 4, 5, 8 and 9, 2014.</p> <p>Facility Number: 000048 Provider Number: 155115 AIM Number: 100275330</p> <p>Survey Team: Pamela Williams RN, TC Julie Baumgartner, RN Shauna Carlson, RN Amy Miller, R.N. Honey Kuhn, RN (December 8 and 9, 2014)</p> <p>Census bed type: SNF/NF: 108 Total: 108</p> <p>Census Payor type: Medicare: 10 Medicaid: 79</p>	F000000	<p>The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation.</p> <p>Due to the relative low scope and severity of this survey, the facility respectfully requests a desk review in lieu of a post-survey revisit on or after January 8, 2015.</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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155115	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/09/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER CARDINAL NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1121 E LASALLE AVE SOUTH BEND, IN 46617
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F000247 SS=A	<p>Other: 19 Total: 108</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality Review completed on December 17, 2014, by Brenda Meredith, R.N.</p> <p>483.15(e)(2) RIGHT TO NOTICE BEFORE ROOM/ROOMMATE CHANGE A resident has the right to receive notice before the resident's room or roommate in the facility is changed. Based on interview and record review, the facility failed to document notification of a change in roommate. This deficiency affected 1 of 1 resident's reviewed for notification of change in roommate. (Resident #113)</p> <p>Findings include:</p> <p>On 12-3-2014 at 12:01 P.M., an interview was conducted with Resident #113. Resident #113 indicated she had gotten a roommate on 8-11-2014, but the staff had never come to tell her, "...I overheard them talking about it in the hallway, and then my roommate came...."</p> <p>On 12-9-2014 at 10:30 A.M., review of</p>	F000247	<p>F247 – Right to Notice Before Room/Roommate Change</p> <p>It is the practice of this provider that a resident has the right to receive notice before the resident's room or roommate in the facility is changed. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: <i>Resident #113</i> has had no recent room/roommate changes and expresses satisfaction with her current room/roommate situation. How other residents having the potential to be affected by the same deficient practice will be</p>	01/08/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155115		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/09/2014	
NAME OF PROVIDER OR SUPPLIER CARDINAL NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 1121 E LASALLE AVE SOUTH BEND, IN 46617			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>Resident #113's record was conducted. Review of a MDS (Minimum Data Set) assessment indicated Resident #113's BIMS (Brief Interview for Mental Status) was 15 out of a possible 15, indicating she was cognitively intact. Resident #113's record showed no documentation of notification of her receiving a roommate.</p> <p>On 12-9-2014 at 10:35 A.M., an interview with the Social Worker was conducted. The social worker indicated she was the one who dealt with notification of roommate changes to residents, "...I usually document it in the progress notes...I will look for it..."</p> <p>On 12-9-2014 at 10:50 A.M., the Social Worker could not produce any documentation that Resident #113 was notified prior to receiving a roommate.</p> <p>On 12-9-2014 at 11:00 A.M., review of the undated "[Corporate Name] Intra-Facility Transfers" policy, received from the Social Worker at this time, indicated "...6. The receiving roommate and/or legal representative will be notified of the new roommate prior to the move. This notification will be documented in the medical record..."</p> <p>On 12-9-2014 at 11:08 A.M., an</p>		<p>identified and what corrective action(s) will be taken: Any resident with a room/roommate change has the potential to be affected by this finding. An audit will be completed by SSD/designee to identify any resident with a room/roommate change in the last 30 days. This audit will ensure that any resident (and/or responsible party) with a room/roommate change or any intra facility transfer received proper notification and that documentation of this notification is recorded in the clinical record.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: A mandatory in-service will be conducted by the DNS/designee on or before 1/8/14. This in-service will include review of the facility policy related to timely resident/responsible party notification of any room/roommate change or any intra facility transfer. The nursing staff will be re-educated on the importance of proper notification and documentation of all room/roommate changes and/or any intra facility transfer. DNS/designee will review the Facility Activity Report daily to ensure room/roommate changes are completed and documented accordingly in the clinical record.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155115	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/09/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER CARDINAL NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1121 E LASALLE AVE SOUTH BEND, IN 46617
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F000280 SS=D	<p>interview with the DON (Director of Nursing) was conducted. The DON indicated Resident #113 was her own representative.</p> <p>3.1-3(v)(2)</p> <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</p>		<p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: This corrective action will be monitored through the facility CQI Program. The SSD/designee will be responsible for completion of the CQI Audit Tool titled, "Social Service Documentation Review" weekly for 4 weeks, then monthly for 6 months. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the CQI Committee for review and follow up.</p> <p>By what date the systemic changes will be completed: Compliance Date = 1/8/2015.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155115	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/09/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER CARDINAL NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1121 E LASALLE AVE SOUTH BEND, IN 46617
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>and revised by a team of qualified persons after each assessment.</p> <p>Based on interview and record review, the facility failed to ensure the care plan of a resident who fell was updated. This deficiency affected 2 of 3 residents reviewed for accidents. (Resident #9 and Resident #72)</p> <p>Findings include:</p> <p>1. On 12-2-2014 at 1:44 P.M. an interview with LPN #6 was conducted. LPN #6 indicated Resident #9 had had a fall on 11-20-2014.</p> <p>On 12-5-2014 at 10:02 A.M., a record review of Resident #9's chart was conducted. Diagnoses included but were not limited to: "...Alzheimer's dementia with behaviors, osteoporosis, mild intellectual disabilities, arthritis, atrial fibrillation...."</p> <p>A Progress Note, dated 11-20-2014 at 11:59 A.M., indicated "...Resident was seen by housekeeping when they went by the room falling and came to get help..."</p> <p>Resident #9's Fall Risk care plan, started 11-05-2012, indicated "...Resident is at risk for fall due to advanced age, dx [diagnosis] arthritis, osteoporosis, impaired vision, history of falls, med use,</p>	F000280	<p>F280 – Participate Planning Care – Revise Care Plan</p> <p>It is the practice of this provider that a comprehensive care plan be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</p> <p><i>Resident #9</i> has been discharged from the facility. <i>Resident #72</i> has been discharged from the facility.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:</p> <p>All residents have the potential to be affected by this finding. A facility audit will be conducted by the Nurse Management Team. This audit will include a fall care plan review for each resident to ensure that all related care plans are accurately reflecting each resident's current status. Fall care plans are reviewed by the Interdisciplinary Team and new interventions are put into place</p>	01/08/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155115		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/09/2014	
NAME OF PROVIDER OR SUPPLIER CARDINAL NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 1121 E LASALLE AVE SOUTH BEND, IN 46617			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>incontinence, history of noncompliance, and confusion, unsteady gait, resident has hx [history] of turning chair and bed alarms off...Approach...[10-17-2014] Provide resident with plastic cup with snap lid for water in bedroom... [9-25-2014] Offer to lay down after meals...[5-21-2014] Pressure pad alarm to stationary chair...[6-5-2013] Keep alarms out of resident reach...[4-18-2013] Assist x [times] 1 with transfers... [12-19-2012] Non skid strips to both sides of bed...[9-6-2012] offer cup with lid at meal time...[9-19-2011] bed alarm to alert staff to unassisted rising... [9-19-2011] keep frequently used items in reach...[9-19-2011] night light... [9-19-2011] non skid footwear... [9-19-2011] Therapy screen quarterly and as needed...."</p> <p>2. On 12/5/14 at 11:29 A.M., a record review of Resident #72's chart was completed. Diagnoses included, but were not limited to: "Dementia with Behavior Disturbances, Cardiomyopathy, Diabetes, Depressive Disorder, Parkinsonism...."</p> <p>A Progress Note for Resident #72, dated 11/12/14, indicated "...writer observed residents eyes roll back behind his head and pass out to the floor while walking in the hall with walker in front of nurses station..."</p>		<p>based on the identified root cause. A mandatory nursing in-service will be conducted on or before 1/8/15 by the DNS/designee. This in-service will include review of the facility policy related to the Fall Management Program and accurate and timely updating of care plans after a fall with appropriate interventions based on the identified root cause of the fall.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: Fall care plans are reviewed by the Interdisciplinary Team and new interventions are put into place based on the identified root cause. DNS/designee will review all resident care plans after resident falls to ensure all appropriate interventions are in place. A mandatory nursing in-service will be conducted on or before 1/8/15 by the DNS/designee. This in-service will include review of the facility policy related to the Fall Management Program and accurate and timely updating of care plans after a fall. All nursing staff will be re-educated on the process of reviewing, updating and following all resident care plans specifically related to falls.</p> <p>How the corrective action(s) will be monitored to ensure the</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155115		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/09/2014	
NAME OF PROVIDER OR SUPPLIER CARDINAL NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 1121 E LASALLE AVE SOUTH BEND, IN 46617			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
F000329 SS=D	<p>On 12/5/14 at 12:10 P.M., review of care plan " Falls," dated 4/12/12 and updated 8/14/14, indicated that the care plan had not been updated after the Resident #72 most recent fall.</p> <p>On 12-9-2014 at 12:35 P.M., an interview with the ED (Executive Director) was conducted. The ED indicated "...the IDT [Inter-Disciplinary Team] is responsible for making sure the care plans get updated...if a resident is sent out to the hospital, they [the IDT team] meet after they [the resident] are readmitted and update the fall care plan...."</p> <p>On 12-9-2014 at 12:50 P.M., review of the "Fall Management Program" policy, last updated 9/2013, received from the ED on 12-8-2014 at 9:00 A.M., indicated "...5. All falls will be discussed by the interdisciplinary team at the 1st IDT meeting after the fall to determine root cause and other possible interventions to prevent future falls...The care plan will be reviewed and updated, as necessary...."</p> <p>3.1-35(d)(2)(B)</p> <p>483.25(l) DRUG REGIMEN IS FREE FROM</p>		<p>deficient practice will not recur, i.e., what quality assurance program will be put into place: Ongoing compliance with this corrective action will be monitored through the facility CQI program. The DNS/designee will be responsible for completion of the CQI Audit tool titled, "Care Plan Updating" weekly for 4 weeks and monthly for 6 months. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the CQI Committee for review and follow up.</p> <p>By what date the systemic changes will be completed: Compliance Date = 1/8/2015</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155115	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/09/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER CARDINAL NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1121 E LASALLE AVE SOUTH BEND, IN 46617
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

	<p>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 complete a required AIMS (Abnormal Involuntary Movement Scale) assessment for a resident who was started on an antipsychotic medication. This deficiency affected 1 of 5 residents reviewed for unnecessary medications. (Resident #88)</p> <p>Findings include:</p> <p>On 12-3-2014 at 10:13 A.M., review of Resident #88's record was conducted. Diagnoses included, but were not limited to: "...depressive disorder, end stage renal</p>	F000329	<p>F329 – Drug Regimen Is Free From Unnecessary Drugs</p> <p>It is the intent of this provider that each resident's drug regimen be free from unnecessary drugs.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</p> <p>Resident #88's AIMS (Abnormal Involuntary Movement Scale) Assessment has been completed.</p> <p>How other residents having the potential to be affected by the</p>	01/08/2015
--	--	---------	--	------------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155115	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/09/2014
NAME OF PROVIDER OR SUPPLIER CARDINAL NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1121 E LASALLE AVE SOUTH BEND, IN 46617		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>disease, dementia with behaviors...."</p> <p>The Physician orders indicated Resident #88 was started on Risperidone (antipsychotic medication) on 4-24-2014. There was no documentation to indicate Resident #88 had an AIMS (Abnormal Involuntary Movement Scale) assessment completed since starting the medication.</p> <p>On 12-9-2014 at 11:10 A.M., an interview with the DON (Director of Nursing) was conducted. The DON indicated "...it looks like it [AIMS assessment] wasn't done...I can't find it...."</p> <p>On 12-9-2014 at 12:03 P.M., review of the undated "[Corporate Name] Psychotropic Medication Management Program," received from the DON at this time, indicated "...3. An AIMS assessment is required for residents who are taking antipsychotic medication. The assessment should be completed within 48 hours of a new order to initiate an antipsychotic and then every six months...."</p> <p>3.1-48(a)(3)</p>		<p>same deficient practice will be identified and what corrective action(s) will be taken:</p> <p>Any resident with orders for an antipsychotic medication has the potential to be affected by this finding. A facility audit will be conducted by the Nurse Management Team. This audit will identify all residents with physician's orders for antipsychotic medications. The Nurse Management Team will then ensure that all residents with orders for antipsychotic medications have a corresponding AIMS (Abnormal Involuntary Movement Scale) Assessment completed. In addition, the Nurse Management Team will monitor all new orders for antipsychotic medications to ensure clinical justification for use, required and appropriate supportive documentation is present as well as thorough assessment is completed including AIMS (Abnormal Involuntary Movement Scale) per facility policy. The Nurse Management Team will ensure that an AIMS (Abnormal Involuntary Movement Scale) Assessment is completed within 48 hours of a new order to initiate an antipsychotic medication and then at least every six months thereafter.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155115	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/09/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER CARDINAL NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1121 E LASALLE AVE SOUTH BEND, IN 46617
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			<p>practice does not recur: The Nurse Management Team will ensure that all residents with orders for antipsychotic medications have a corresponding AIMS (Abnormal Involuntary Movement Scale) Assessment completed. In addition, the Nurse Management Team will monitor all new orders for antipsychotic medications to ensure clinical justification for use, required and appropriate supportive documentation is present as well as thorough assessment is completed including AIMS (Abnormal Involuntary Movement Scale) per facility policy. The Nurse Management Team will ensure that an AIMS (Abnormal Involuntary Movement Scale) Assessment is completed within 48 hours of a new order to initiate an antipsychotic medication and then at least every six months thereafter. A mandatory nursing in-service will be conducted by the DNS/designee on or before 1/8/15. This in-service will include review of the facility policy titled, Psychoactive Medication Management Program. Nursing staff will be re-educated regarding timely and accurate completion of all necessary assessments including AIMS (Abnormal Involuntary Movement Scale) as well as the appropriate timeline for completion. How the corrective action(s) will be monitored to ensure the</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155115	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/09/2014
NAME OF PROVIDER OR SUPPLIER CARDINAL NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1121 E LASALLE AVE SOUTH BEND, IN 46617		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F009999	3.1-14 PERSONNEL (q) Each facility shall maintain current and accurate personnel records for all employees. The personnel records for all employees shall include the following: (6) Position in the facility and job description. (7) Documentation of orientation to the facility and to the specific job skills.	F009999	deficient practice will not recur, i.e., what quality assurance program will be put into place: To ensure ongoing compliance with this corrective action, the DNS/designee will monitor all new orders for antipsychotic medications to ensure clinical justification for use, required and appropriate supportive documentation is present as well as thorough assessment is completed including AIMS (Abnormal Involuntary Movement Scale) per facility policy. The DNS/designee will also be responsible for completion of the CQI Audit tools titled, "Unnecessary Medications" weekly for 4 weeks, monthly for 6 months. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the CQI Committee for review and follow up. By what date the systemic changes will be completed: Compliance Date = 1/8/2015.	01/08/2015	
			F9999 – Final Observations/Personnel It is the practice of this provider to maintain current and accurate personnel records for all employees. What corrective action(s) will be accomplished for those		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155115		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/09/2014	
NAME OF PROVIDER OR SUPPLIER CARDINAL NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 1121 E LASALLE AVE SOUTH BEND, IN 46617			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>(8) Signed acknowledgement if orientation to resident's rights. This state rule was not met as evidenced by: Based on record review and interview, the facility failed to ensure documentation of job orientation was complete for 1 of 10 employee records reviewed. (Employee #1). Findings include: On 12/9/14 at 10:30 AM, review of the record for the Employee #1, hired 10/28/14, indicated the Orientation Checklist, signed Job Description, and Resident's Rights was missing from the file. On 12/9/14 at 12:34 P.M., an interview with the ED (Executive Director) indicated that " we do not have the Orientation Checklist, Job Description, or Resident's Rights for Employee #1's personnel file". The ED further indicated that "all new employees should have a completed orientation checklist, job description and resident's right documented in their file." On 12/9/14 at 12:36 P.M., review of the undated " New Hire General Orientation Policy" received from the ED, indicated " Process: 1... a. Administrative procedures. i. In-Service Records... iv. New Hire Orientation... viii. Job specific Orientation...." 3.1-14(q)(6)</p>		<p>residents found to have been affected by the deficient practice: <i>Employee #1's</i> personnel file has been reviewed and updated and now includes all necessary documents related to her employment including her Job Specific Orientation Checklist, signed Job Description and Resident Rights Acknowledgement. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All employees have the potential to be affected by this finding. An audit will be completed by ED/designee of all employee files. This audit will ensure that all employee personnel files contain the proper and appropriate documents per facility policy including Job Specific Orientation Checklists, signed Job Descriptions and Resident Rights Acknowledgements. Any missing or incomplete items noted will be corrected immediately. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: The ED/designee will be responsible for in-servicing and re-educating each Department Head regarding the paperwork and documents required for each</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155115	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/09/2014
NAME OF PROVIDER OR SUPPLIER CARDINAL NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1121 E LASALLE AVE SOUTH BEND, IN 46617		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	3.1-14(q)(7) 3.1-14(q)(8)		<p>employee personnel file. The ED/designee will be responsible for ensuring that all necessary and appropriate paperwork including Job Specific Orientation Checklists, signed Job Descriptions and Resident Rights Acknowledgement Forms are obtained and filed in the personnel record per facility policy by using the Employee File Checklist.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: To ensure ongoing compliance with this corrective action, the ED/designee will be responsible for completion of the CQI Audit Tool titled, "Personnel and Confidential Employee File Checklist" weekly for 4 weeks and monthly for 6 months. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the CQI Committee for review and follow up.</p> <p>By what date the systemic changes will be completed: Compliance Date = 1/8/2015</p>		