

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155496	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/30/2012
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NAME OF PROVIDER OR SUPPLIER KINDRED NURSING AND REHABILITATION VALLEY VIEW	STREET ADDRESS, CITY, STATE, ZIP CODE 333 W MISHAWAKA RD ELKHART, IN 46517
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F0000	<p>This visit was for Recertification and State Licensure Survey.</p> <p>Survey dates: August 22, 23, 24, 25, 26, 27, 28, 29 and 30, 2012.</p> <p>Facility number: 000523 Provider number: 155496 AIM number: 100266930</p> <p>Survey team: Shelly Vice, RN-TC Honey Kuhn, RN (8/22, 8/23, 8/24, 8/27, 8/29, 8/30, 2012) Carol Miller, RN (8/22, 8/23, 8/24, 8/27, 8/29, 2012)</p> <p>Census bed type: SNF/NF: 94 Total: 94</p> <p>Census payor type: Medicare: 10 Medicaid: 67 Other: 17 Total: 94</p> <p>These deficiencies reflect state findings cited in accordance with 410</p>	F0000	<p>This Plan of Correction is the center's credible allegation of compliance Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</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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	IAC 16.2. Quality review completed on September 7, 2012 by Bev Faulkner, RN			
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F0226 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 interviews and record reviews, the facility failed to identify and report an alleged allegation of verbal treatment for 1 of 7 sampled residents interviewed (Res. #34).</p> <p>Findings include:</p> <p>Resident #34 was interviewed on 8/22/12 at 10:04 a.m. Resident #34 indicated a staff member had yelled and been rude to the resident when she was first admitted to the facility. Resident #34 indicated after she told her sister and the her sister spoke with a staff member at the facility. The resident was unsure of the staff members name and or title. The resident further indicated after she told her sister about the alleged verbal allegation, it never occurred again. The resident further indicated she was not afraid of direct care staff and had not been treated roughly by staff.</p> <p>Interview with the Administrator on 8/27/12 at 9:20 a.m., indicated</p>	F0226	F2261. Resident #34 is no longer residing at the facility. The Administrator, or his designee, has counseled and in-serviced staff members involved in this event found the correct procedures were followed.2. The Social Services department interviewed and observed other residents to identify any other residents having the potential to be affected by potential failure to identify and report abuse and immediately forward any findings to the Administrator for needed follow up and corrective action.3. The Administrator, or his designee, will in-service the facility staff on the Abuse Policy with an emphasis on the prevention, intervention, and reporting components. The Staff Development Coordinator will include information on the Abuse Policy with an emphasis on the prevention, intervention, and reporting components in the orientation of new personnel. The Administrator, or his designee, will review each investigation while it is being conducted to assure full implementation of the policy to ensure and maintain compliance	09/29/2012			

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	<p>Resident #34 was interviewed on 8/24/12 at 3:00 p.m., by the Administrator and the Director Nursing Services (DNS) and the resident had indicated CNA #3 was rough during her care in early April 2012 when the resident was admitted to the facility. The Administrator indicated CNA #3 was suspended pending the investigation of the alleged allegation. The investigation included interviews with staff members, and numerous residents and the alleged allegation was unsubstantiated due to lack of evidence.</p> <p>The Administrator indicated Resident #34 had not reported this alleged allegation of roughness until now to anyone.</p> <p>Unusual Occurrence Report Reasonable Suspicion of a Crime against a Resident Report form, dated 8/24/12 at 3:00 p.m., indicated "...The resident ... could not be very specific regarding the nature of the rough treatment, but said the CNA has not been rough with her in the time since the first days of her stay at Valley View. When asked why she had not brought this to anyone's attention previously the resident stated she hadn't felt comfortable</p>		<p>and follow up on at least a monthly basis. Corrective action will be taken immediately for elements found not to be fully implemented.4. The Administrator, or his designee, will monitor through Review of responses to QIS questions on abuse at least monthly. to assure all components of the Abuse Policy are fully implemented. The results of these audits will be reviewed and analyzed with a subsequent plan of action developed and implemented as indicated at the monthly Performance Improvement Committee Meeting. The PI Committee will review monthly for 6 months. The Administrator is responsible for overall compliance.</p>		

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	<p>mentioning it till now."</p> <p>A confidential interview on 8/28/12 at 10:15 a.m., by phone in regard to the alleged allegation of abuse indicated "yes the resident did tell her that she was handled roughly when she first got here" and named CNA #3. The confidential interviewee indicated she had told RN #1 in regard to resident's statement of being handled roughly and indicated CNA #3 did not care for the resident after she reported the alleged allegation of abuse.</p> <p>Interview on 8/29/12 at 8:20 a.m., with RN #2 she indicated she saw and spoke with the resident almost every day and the resident did not indicate any concerns or alleged allegations of abuse.</p> <p>Interview with the Administrator in regard to the alleged allegation of abuse indicated on Saturday 8/25/12 he had spoken with the resident's sister by phone and the sister did not voice any concerns about any allegations.</p> <p>The SSD indicated at times the resident's sister becomes confused and had non-sensible speech. The Social Service Designee (SSD) indicated she had a careplan</p>			

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	<p>conference with the resident's sister on 4/19/12 by phone and the sister did not indicate any concerns with alleged allegation of abuse.</p> <p>Review of CNA #3's Employee Record File on 8/29/12 indicated there were no disciplinary reports for CNA #3 and had been inserviced annually for abuse protocol</p> <p>Abuse Prevention Policy dated 4/28/09 received for the Administrator on 8/27/12 at 10:00 a.m. "Verbal , sexual, physical, and mental abuse,...are strictly prohibited. All alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown origin...are reported immediately to the administrator of the facility and to other officials in accordance with State law...."</p> <p>3.1-28(a)</p>			

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F0241 SS=D	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>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.</p> <p>Based on interviews and observation, the facility failed to address residents appropriately prior to entering resident's rooms and during activity of daily living care. This affected 2 of 40 sampled residents. (#59 and #63).</p> <p>Findings include:</p> <p>On 8/22/12 at 12:00 p.m., an interview was conducted with Resident #59 in her room. It was noted upon interview that Resident #59 indicated in general the staff were not accommodating in her personal choices during her activities of daily living (ADL). She stated, "... they are so demanding...they don't give you a choice to do what you want to do... you have to do what 'they' say...and they're not very nice about it..."</p> <p>On 8/24/12 at 9:10 a.m., the privacy curtain was observed to be pulled around the bed of Resident # 63. With permission given by the resident, the curtain was pulled back</p>	F0241	<p>F 241 1. Resident #59 and #63 have been assessed and are being monitored by Social Services for any needed follow up concerns. 2 The Social Services department interviewed and observed to identify those residents who feel they are not addressed appropriately by staff prior to entering their rooms or during activity of daily care. Director of Nursing or designee, through record review, observation and concern/ grievance review has identified non-interviewable residents who are not addressed appropriately by staff prior to entering their rooms or during activity of daily care. Educational and/or disciplinary corrective action will be taken as needed. 3. The Staff Development Coordinator or designee will conduct an in-service with the staff on resident dignity and respect with an emphasis on addressing residents appropriately prior to entering resident's rooms and treating residents with dignity and respect during activity of daily living. The Staff Development Coordinator or designee will include information regarding</p>	09/29/2012			

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	<p>and Resident #63 was observed lying on her bed, uncovered, exposing her absorbency disposable brief. The smell of bowel movement was noted. In interview at this time, Resident #63 stated, "I was hoping you were her... I've been waiting for over 15 minutes... are they coming back... they said they would and they haven't and I need some help..."</p> <p>On 8/24/12 at 9:30 a.m., an observation of CNA #51 was made during ADL care provisions. CNA #51 knocked on the shared room door of Resident's #59 and #63. Simultaneously, CNA #51 entered the room addressing the room with an overly abrupt, loud "...NEXT..."</p> <p>On 8/24/12 at 9:32 a.m., Resident # 59 in Bed B, requested, "... I need some help too..." CNA #51 was heard to reply, "You've already been done," in an abrupt, callous tone of voice.</p> <p>3.1-3(t)</p>		<p>maintaining and/or enhancing patient dignity and addressing residents appropriately prior to entering resident's rooms and during activity of daily living during orientation of all new personnel. The Social Service Director, or her designee, will conduct three individual and family interviews weekly to ensure and maintain compliance and follow up on a monthly basis, assuring residents are being treated with dignity and respect. Any deficient findings will at least monthly and as needed be reported to the Administrator immediately for appropriate intervention. 4. The Director of Nursing, or her designee, will conduct 5 observations per week that staff are addressing residents appropriately prior to entering resident's rooms and treating residents with dignity and respect during activity of daily living care. The results of these audits will be reviewed and analyzed with a subsequent plan of action developed and implemented as indicated at the monthly Performance Improvement Committee Meeting to ensure and maintain compliance. The PI Committee will review monthly for 6 months. The Administrator is responsible for overall compliance</p>				

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F0253 SS=B	<p>483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES</p> <p>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. Based on observations and interviews, the facility failed to provide a clean window for 1 of 40 sampled Residents (#82) and failed to assure the handle to the residents bathroom door was in working order. This affected 1 of 40 Residents sampled (#71).</p> <p>Findings include:</p> <p>1).On 8/25/12 at 10:00 a.m., an observation was made of Resident #82's room. Resident #82 was sitting in a wheelchair as she looked out her room window. Upon an interview with Resident #82, it was noted that she enjoyed looking outside and watching the birds eat from the bird feeders outside her resident room window. It was noted, "...I sure would love to have this window clean ... they (the facility) cannot clean it because it is a double paned window and the dirty stuff is inside there..."</p> <p>Upon observations of Resident #82's window it was noted to be a double paned window with the residue from past condensation adhering to the</p>	F0253	F2531. a. The window in resident #82's room has been replaced.b. The loose handle to resident #71's bathroom door has been repaired. 2. The Environmental Supervisor or designee will make daily environmental rounds on each scheduled day of service of resident rooms and common areas to assure the facility is maintained in a sanitary, orderly and comfortable manner. The Environmental Supervisor or designee will review any findings with the Administrator and corrective action will be implemented as indicated. 3. The Staff Development Coordinator or designee will in-service staff on completion of repair requisitions when needed. The SDC or designee will include the procedure for completing repair requisitions in the orientation of appropriate new hires as indicated. 4. The Environmental Supervisor or designee will monitor through environmental rounds on a daily basis on each scheduled day of service to assure that the facility is maintained in a sanitary and comfortable manner. The data will be reviewed and analyzed monthly for three months and then quarterly at the monthly	09/29/2012			

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	<p>inside surface of the inner aspect of the window. The grimy, film was hindering a clear view by Resident # 82 out of her room window.</p> <p>2). On 8/23/12 at 1:30 p.m., an interview was conducted with Resident #71. The resident commented about the handles to the bathroom, "...they fall off in your hands when you go to use them... I've reported it several times before, and I've watched the staff holding that handle in their own hands time and time again... they need to get that fixed..."</p> <p>An observation was made on 8/23/12 at 1:30 p.m., during the interview with Resident #71 and the handles were loosely attached to the door.</p> <p>3. On 08/29/2012 at 8:45 a.m. to 9:10 a.m., an environmental tour was conducted with the Maintenance Director and the Administrator.</p> <p>In Resident #82's room the window to the outside was streaked with water spots and resident indicated she would like to look out the window.</p> <p>During observation of Resident #71's bathroom, the door handle fell off as the bathroom door was being closed.</p>		<p>Performance Improvement Committee Meeting with a subsequent plan of action developed and implemented as indicated to ensure and maintain compliance. The PI Committee will review monthly for 6 months. The Administrator is responsible for the overall compliance.</p>		

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	<p>Interview with the Housekeeping Supervisor on 8/29/12 at 8:45 a.m., in regard to Resident #82's window, indicated the window was replaced yesterday and the window itself was not dirty.</p> <p>3.1-19(f)(5)</p>			

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F0282 SS=D	<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 interviews, the facility failed to clarify and record the parameters for application of a hand splint for 1 of 1 residents in a sample of 5 who were reviewed for splints and devices. (Resident #129)</p> <p>Finding includes:</p> <p>LPN #30 was interviewed, on 08/22/12 between 10:00 a.m. and 11:00 a.m., in regards to Resident #129. LPN #30 indicated Resident #129 had been recently admitted and had a contractures to her left hand. LPN #30 indicated the resident had a splint (a device to prevent worsening of a contracture) to be worn on the left hand/wrist.</p> <p>Resident #129 was interviewed on 08/22/12 at 1:30 p.m., while lying in bed. Resident #129 did not have a splint on. A splint was noted lying on the bedside stand.</p> <p>Resident #129 was observed on 08/24/12 seated in her wheelchair</p>	F0282	<p>F2821. Resident #129's care plan and MAR have been updated to reflect current MD orders. 2. The Director of Nursing or her designee will conduct weekly audits of current residents to ensure the implementation of physician order clarification and care plan follow through. Any residents found to have physician orders in need of clarification or lack of care plan follow through will have corrective plan of action initiated as needed. 3. The Staff Development Coordinator or designee will in-service licensed staff regarding the need for physician order clarification and follow through of the written plan of care. The Staff Development Coordinator or designee will include physician order clarification as needed and follow through of written plan of care with qualified staff during the orientation of appropriate new hires. 4. The Director of Nurses or designee will conduct observation of splints and other devices 5 times per week times per week on all shifts to ensure and maintain compliance and follow up at least monthly. The results of these audits will be reviewed and</p>	09/29/2012

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	<p>and no splint was observed to the left hand.</p> <p>Resident #129 was observed, on 08/28/12 at 8:04 a.m., seated in the MDR (Main Dining Room). The resident's splint was not on the left hand.</p> <p>The record of Resident #129 was reviewed on 08/27/12 at 2:15 p.m. Res #129 was admitted to the facility on 08/07/12 with diagnoses including, but not limited to, CVA (Cerebral Vascular Accident: stroke) with weakness, CHF (Congestive Heart Failure), left side hemiparesis (limited mobility), diabetes, and gout.</p> <p>Review of the admission orders, dated, 08/07/12, indicated: "08/07/12 (L) (left) wrist and hand brace as directed"</p> <p>Review of a Care Plan, titles "Contractures Potential and Actual", dated 08/20/12, indicated: "Problem...: Resident has impaired functional mobility. Resident has Contracture(s): Left arm & (and) Left leg.... Actual contracture of: Left arm" "Approach: Apply devices to affected joints as ordered, observe for redness."</p>		<p>analyzed with a subsequent plan of action developed and implemented as indicated at the monthly Performance Improvement Committee Meeting to ensure and maintain compliance. The PI Committee will review monthly for 6 months. The Administrator is responsible for overall compliance.</p>				

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	<p>Review of the MARs (Medication Administration Record) and TARs (Treatment Administration Record) for 08/2012 indicated no documentation to direct staff in regards to the left hand/wrist splint/brace.</p> <p>Review of a CNA worksheet for Resident #129 indicated: "(L) side CVA,..." There was no indication the resident had a splint/brace.</p> <p>LPN #26 was interviewed on 08/28/12 at 2:45 p.m. LPN #26 indicated she applied the brace to the resident prior to end of shift on the evenings she worked. LPN #26 reviewed the MARs and TARs for Resident #129 and indicated there was no direction in regards to application of the splint to the left hand and the physician's order should have been clarified.</p> <p>Review of a Policy and Procedure, "Range of Motion", revised 08/31/11 and provided by the DNS (Director Nursing Services) on 08/28/12 at 1:00 p.m., indicated: "Policy...care and treatment are provided to help the patient reach and maintain his/her highest level of range of motion possible and to prevent avoidable decline."</p>						

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	<p>"Compliance Guidelines... 2. Preventive care includes, but is not limited to:...</p> <p>d. Application of splints and braces, if necessary."</p> <p>3.1-35(g)(2)</p>			

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F0314 SS=D	<p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>Based on interviews, record reviews and observation, the facility failed to prevent an excoriated area on the coccyx from developing into an unstageable pressure ulcer of 1 of 2 sampled reviewed for pressure ulcers. (Resident #34).</p> <p>Findings include:</p> <p>The record for Resident #34 was reviewed on 8/27/12 at 9:00 a.m. The resident was readmitted to the facility from the hospital on 4/11/12, with diagnoses including, but not limited to, diabetes type 2, morbid obesity, hypertension, hyperlipidemia, chronic venostasis of the lower extremities, mobility impairment.</p> <p>Hospital Nurses Notes, dated 4/10/12 at 8:57 a.m., indicated the resident had a incontinence dermatitis due to</p>	F0314	F3141. Resident #34 is not a resident of the facility at this time. 2. The Director of Nursing or designee will review the provision of care and services to residents with pressure ulcers and residents deemed at risk for pressure ulcers to ensure Kindred policies and procedures for prevention and treatment of pressure ulcers is in effect and initiate corrective action as indicated. 3. The Staff Development Coordinator or designee will in-service the nursing staff in the delivery of necessary treatment and services to promote healing and prevention of pressure ulcers. In-services for Nursing staff will include the Kindred policies and procedures related to pressure ulcer prevention and treatment. The Staff Development Coordinator or designee will review the Skin Integrity Program with appropriate nursing staff during orientation. 4. The	09/29/2012			

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	<p>incontinence and calazime cream was applied to the affected area.</p> <p>The Admission Physician's Orders, dated 4/11/12, indicated an order for a multivitamin with minerals and iron 1 tablet to be administered 1 time a day to the resident.</p> <p>Interview with RN #2 on 8/28/12 at 3:15 p.m., in regard to the resident's treatment of the excoriated area, indicated the admission orders from the hospital, dated 4/11/12, did not mention the excoriation or have an order for treatment to the excoriated area to the resident's perineum-rectal areas.</p> <p>Patient Nursing Evaluation form from readmission, dated 4/11/12, indicated Resident #34 had excoriation to perineum-rectal and groin areas.</p> <p>Resident Progress Notes, dated 4/11/12 at 2100 (9:00 p.m.), a nursing entry indicated the resident's indwelling urinary catheter was removed and "...c/o (complaint of) severe pain when attempt to turn to check coccyx was unable to (check) this shift."</p> <p>The Braden Scale for Predicting Pressure Sore Risk, dated 4/11/12,</p>		<p>interdisciplinary team will review the status of all pressure ulcers at least weekly to ensure appropriate care and treatment interventions are in place. The facility wound physician report will be reviewed weekly by the interdisciplinary team to also ensure appropriate treatments and interventions are being followed. The Director of Nursing or designee will review treatment records and pressure ulcer monitoring reports at least weekly to insure appropriate interventions are in place to promote healing and ensure and maintain compliance and follow up on a monthly basis. The results of these audits will be reviewed and analyzed with a subsequent plan of action developed and implemented as indicated at the monthly Performance Improvement Committee Meeting to ensure and maintain compliance. The PI Committee will review monthly for 6 months. The Administrator is responsible for overall compliance.</p>		

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	<p>indicated a score of 16 indicating the resident was at risk for the development of pressure ulcers.</p> <p>Pressure Ulcer Prevention policy, dated 4/28/09, received on 8/28/12 at 10:00 a.m., from RN #2 was reviewed and indicated the Pressure Ulcer Braden Scale was to be done on admission and then weekly thereafter times 4 weeks.</p> <p>Interview with RN #2 on 8/27/12 at 10:00 a.m., in regard to the Braden Scale indicated the Braden Scale should had been done weekly times 4 after the resident's admission and was unsure why this had not been done.</p> <p>Physician's Call Log form, dated 4/12/12, indicated Resident #34's Physician was notified in regard to the perineum-rectal excoriation and to follow the Physician's protocol.</p> <p>An untitled and undated form was received from RN #2 and was reviewed on 8/28/12 at 2:00 p.m. RN #2 indicated the form was the resident's physician's protocol for wound care. The form indicated "...4) If a stage 2 pressure ulcer and has no drainage or signs and symptoms of infection start Chalet cream...."</p>			

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	<p>A Temporary Problems Care Plan form, dated 4/11/12, indicated the resident had a urinary tract infection and excoriation to perineum and groin areas and to treat as ordered.</p> <p>A Skin at Risk Care Plan, dated 4/12/12, indicated approach complete a pressure ulcer risk assessment weekly times 4 weeks, complete skin condition check at 24 hours, 48 hours and 72 hours after admission to identify a deep tissue injury. The Care Plan also indicated to follow the Physician's Orders for skin care and treatments. "... (Utilize Best Practice Guidelines)...." A pressure relieving cushion for the wheel chair and mattress was initiated for the resident.</p> <p>Best Practice Guidelines for Prevention/ Pressure Ulcer/ Wound Care form received and reviewed from Care Coordinator RN #2, dated 1/12/12, indicated for stage 1 pressure ulcer apply barrier cream to area affected by moisture after every incontinent episode.</p> <p>Interview with the RN #2 on 8/28/12 at 3:15 p.m., indicated the CNAs had applied the barrier cream to the resident's excoriation after every</p>			

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	<p>incontinent episode the resident had.</p> <p>A Medical Nutrition Therapy Assessment, dated 4/17/12, indicated the resident had excoriation to the groin.</p> <p>Shower sheets, dated 4/18, 4/24, 4/27, 5/8, 5/15, 5/18, and 5/22/12, did not indicate any skin issues for the resident.</p> <p>The Minimum Data Set Assessment (MDS), dated 4/18/12, indicated the resident was totally dependent on staff with a 2 plus person assist with bed mobility. The resident had occasional urinary incontinence of less than 7 episodes and one episode of bowel incontinence.</p> <p>The resident's skin assessment indicated moisture associated skin damage.</p> <p>Resident Weekly Skin Check Sheets, dated 4/19/12, and completed by a Licensed nurse indicated no new skin issues for Resident #34.</p> <p>Nurses Notes, dated 5/3/12, did not indicate documentation of any change in the resident's pressure ulcer.</p> <p>Physician's Orders, dated 5/3/12, indicated to cleanse the open areas</p>			

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	<p>on the coccyx with normal saline and apply calcium alginate with silver and cover with a dry dressing and change the dressing every other day and as needed.</p> <p>The Pressure Ulcer Weekly Log, dated 5/4/12, indicated an unstageable pressure ulcer on the resident's coccyx was found on 5/3/12 and measured 0.9 centimeters (cm) length by 0.3 cm with zero depth. The treatment ordered by the resident's physician was to apply Santyl ointment every other day to the pressure area.</p> <p>Pressure Ulcer Weekly Log, dated 5/11/12, indicated the pressure area on the coccyx was a stage 2 had improved and measured at 0.5 cm in length and 0.4 cm in width and 0.2 cm in depth.</p> <p>A Debridement Note, signed by the resident's Wound Physician, dated 5/4/12, indicated "No sharp debridement done."</p> <p>A Wound Form, dated 5/4/12, indicated an initial assessment was completed by the Wound Physician and the pressure area on the coccyx was unstageable with 100% slough and measured 0.4 cm in length and 0.3 in width.</p>			

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	<p>Interview with RN #2 on 8/28/12 at 8:15 a.m., in regard to the pressure ulcer on the coccyx , indicated Resident #34 was seen by the Wound Physician on a weekly basis and documented the progress of the pressure ulcer weekly. RN #2 also indicated an indwelling urinary catheter was inserted</p> <p>Nutritional Progress Notes, dated 5/7/12, for follow-up indicated the stage 2 on the coccyx had improved and to continue with the multivitamin with minerals and iron for wound healing and nutritional support.</p> <p>Observation on 8/28/12 at 2:45 p.m., with RN#1, the pressure ulcer on the coccyx measured 1.8 cm in length, 0.3 cm in width and 0.2 cm in depth. The skin surrounding the pressure ulcer was pink without odor or drainage present. There was no slough or eschar noted on resident's pressure ulcer.</p> <p>3.1-40(a)(1) 3.1-40(a)(2)</p>				

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F0318 SS=D	<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 observations, record review and interview, the facility failed to provide Passive Range of Motion (PROM) and splint application to increase range of motion or prevent decrease in range of motion for 1 of 1 residents reviewed for PROM and splint application in the sample of 8. (Res. #129).</p> <p>Finding includes:</p> <p>LPN #30 was interviewed on 08/22/12 between 10:00 a.m. and 11:30 a.m., in regards to Resident #129. LPN #30 indicated Resident #129 had been recently admitted and had a contractures to her left hand. LPN #30 indicated Resident #129 had a hand/wrist splint.</p> <p>Resident #129 was observed on 08/22/12 at 1:30 p.m., while lying in bed. Resident #129 did not have a splint on. A splint was noted lying on the bedside stand.</p>	F0318	F3181. Resident #129's order was clarified and Passive Range of Motion is being done and the splint has been applied daily. 2. The Director of Nursing or her designee will conduct audits to ensure the implementation of Passive Range of Motion and splint application for current residents. Any residents found to have lack of follow through for Passive Range of Motion or splint application will have corrective plan of action initiated as needed. 3. The Staff Development Coordinator or designee will in-service nursing staff regarding the need for Passive Range of Motion being done as ordered and splint application as ordered. The Staff Development Coordinator or designee will include Passive Range of Motion being done as ordered and splint application as ordered during in the orientation of appropriate new nursing staff hires. 4. The Director of Nurses or designee will conduct audits of Passive Range of Motion being done as ordered and splint application as ordered three times per week to ensure and maintain	09/29/2012			

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	<p>Resident #129 was observed on 08/24/12 seated in her w/c (wheelchair) and no splint was observed to the left hand.</p> <p>Resident #129 was observed, on 08/28/12 at 8:04 a.m., seated in the MDR (Main Dining Room). The resident's splint was not on the left hand.</p> <p>The record of Resident #129 was reviewed on 08/27/12 at 2:15 p.m. Res #129 was admitted to the facility on 08/07/12 with diagnoses including, but not limited to, CVA (Cerebral Vascular Accident: stroke) with weakness, CHF (Congestive Heart Failure), left side hemiparesis (limited mobility), diabetes, and gout.</p> <p>Review of the admission orders, dated, 08/07/12, indicated: "08/07/12 (L) (left) wrist and hand brace as directed"</p> <p>Review of a Care Plan, titles "Contractures Potential and Actual", dated 08/20/12, indicated: "Problem...: Resident has impaired functional mobility. Resident has Contracture(s): Left arm & (and) Left leg.... Actual contracture of: Left arm" "Approach: Provide PROM to affected</p>		<p>compliance and follow up on a monthly basis. The results of these audits will be reviewed and analyzed with a subsequent plan of action developed and implemented as indicated at the monthly Performance Improvement Committee Meeting. The PI Committee will review monthly for 6 months. The Administrator is responsible for overall compliance.</p>				

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	<p>area during ADL's (Activities Daily Living: bathing, dressing, transferring, etc.). Gradually decrease assistance (as tolerated) to encourage progress to Active Assisted ROM (Range of Motion).</p> <p>Report and document any declines in ability.</p> <p>Refer to therapy as necessary.</p> <p>Apply devices to affected joins as ordered, observe for redness."</p> <p>Review of the MARs (Medication Administration Record) and TARs (Treatment Administration Record) for 08/2012 indicated no documentation to direct staff in regards to PROM.</p> <p>Review of a CNA worksheet for Resident #129 indicated: "(L) side CVA,..." There was no indication the resident was to receive PROM or had a splint/brace.</p> <p>The DNS (Director Nursing Services) was interviewed on 08/28/12 at 1:00 p.m. The DNS indicated PROM should be provided by the CNA's during care and documentation should be on the care tracking form.</p> <p>Review of the record indicated no</p>			

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	<p>care tracking form or documentation to indicate Resident #129 had received any PROM since admission on 08/07/12.</p> <p>Review of a Policy and Procedure, "Range of Motion", revised 08/31/11 and provided by the DNS on 08/28/12 at 1:00 p.m., indicated: "Policy...care and treatment are provided to help the patient reach and maintain his/her highest level of range of motion possible and to prevent avoidable decline."</p> <p>"Compliance Guidelines... 2. Preventive care includes, but is not limited to:...</p> <p>b. Passive range of motion exercise performed by staff, c. Active-assistive range of motion exercise performed by the patient and staff, and d. Application of splints and braces, if necessary."</p> <p>Review of Policy and Procedure, "Range of Motion Exercises", revised 04/28/09 and provided by the DNS at the time, indicated: "Rationale: Range of motion (ROM) exercises are indicated for the resident with temporary or permanent loss of mobility,...and as a restorative measure to prevent loss of function...</p>			

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	Passive ROM: Assigned staff provides the movement...." 3.1-42(a)(2)				

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F0323 SS=D	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on record review and interview, the facility failed to follow the care plan in regards to supervision to prevent falls for 1 of 4 residents in a sample of 4 residents reviewed for falls. (Res #22).</p> <p>Finding includes:</p> <p>The record of Resident #22 was reviewed on 08/28/12 at 9:48 a.m. Resident #22 was admitted to the facility on 06/08/05 with diagnoses including, but not limited to, TBI (Traumatic Brain Injury), GERD (Gastro-Esphogcal Reflux Disorder), rhinitis, and muscle spasms.</p> <p>Review of "Resident Progress Notes" for Resident #22 indicated: "06/08/12 0045 (12:45 a.m.) ...Resting quietly in bed."</p> <p>"(no date or time) Pt (patient) found on floor this shift in room. 0 (no) injuries noted, neuros (neurovascular) started. DNS (Director Nursing</p>	F0323	F3231. Resident # 22 has been reassessed for fall prevention interventions with his plan of care updated as needed. 2. The Director of Nursing or designee will review the plan of care and recommended interventions along with staff awareness and compliance with implementation of interventions for residents deemed at risk for falls and initiate corrective action as indicated. 3. The Staff Development Coordinator or designee will in-service staff on the Kindred policy and procedures related to the fall prevention program. In-services will include following interventions to prevent falls, observing for potential hazardous issues and how to intervene appropriately. The Staff Development Coordinator or designee will review the Fall Prevention Program with appropriate new hires during orientation. 4. The interdisciplinary team will review all incidents and accidents on the next scheduled day of service to ensure appropriate plan of care and interventions have been implemented and are in place. The Director of Nursing or	09/29/2012

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	<p>Services), notified....Pt. left in room alone by aid (sic)...."</p> <p>"06/10/12 0115 (1:15 a.m.) Fall f/u (follow-up)..."</p> <p>Review of a "POST FALL EVALUATION", dated 06/09/12, indicated the fall occurred at 01030 (sic) (10:30 a.m.) and was "unwitnessed".</p> <p>"INTERVENTION IN PLACE AT TIME OF FALL: Alarm". There was no indication if the alarm was on the resident or sounding.</p> <p>"PAIN/FALL HISTORY: Fell last 30 days: 06/05/12"</p> <p>"Summary of Interdisciplinary Team: Proper intervention wasn't utilized. Staff member educated on proper intervention...."</p> <p>The summary of the Interdisciplinary Team did not indicate what interventions were not being utilized to promote resident safety.</p> <p>Review of a Care Plan for Resident #22, titled, "Falls", and updated on 06/03/12, indicated:</p> <p>"At risk for fall related injury as evidenced by:</p> <p>Disease process/condition: TBI Functional problem: Non-ambulatory (does not walk). Hoyer lift (a device which requires 2 staff to assist</p>		<p>designee will monitor through 5 observations per week on all shifts, and record review fall prevention care plans and assure interventions are in place to ensure and maintain compliance. The results of these audits will be reviewed and analyzed with a subsequent plan of action developed and implemented as indicated at the monthly Performance Improvement Committee Meeting. The PI Committee will review monthly for 6 months. The Administrator is responsible for overall compliance.</p>		

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	<p>resident in transfers) all transfers... Other: Contractures & spasticity which makes positioning difficult. "</p> <p>"Approach:... Provide environmental adaptations: Call light within reach..."</p> <p>"Additional approaches: Pull tab alarm (an alarm which goes off when a resident attempts to arise from bed &/or chair) to bed & chair. Back to bed when in room. Lay down after meals."</p> <p>The DNS (Director Nursing Services) was interviewed on 08/28/12 at 1:30 p.m. The DNS was queried in regards to what interventions were not done by the staff member. The DNS indicated Resident #22 should not be left unsupervised while up in his chair.</p> <p>Review of a CNA worksheet, provided on 08/23/12 at 8:00 a.m. by the DNS, indicated for Resident #22, under comments: "...do not leave in room unless in bed, ...broda chair, lay down after meals."</p> <p>Review of a Policy and Procedure, titled, "Accidents and Supervision to Prevent Accidents", revised 04/28/12, indicated:</p>			

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	"Policy The center (facility) provides an environment that is free from accident hazards over which the center has control and provides supervision and assistive devices to each patient to prevent avoidable accidents...." 3.1-45(a)(2)			

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F0333 SS=D	<p>483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. Based on observation, record review, and interviews, the facility failed to assure the correct route of medication administration for 1 of 13 residents observed during the medication pass. (Resident #1)</p> <p>Finding includes:</p> <p>LPN #27 was observed during the medication pass, on 08/28/12 at 8:10 a.m., administering medications to Resident #1. Resident #1 was observed to receive 7 medications via (by way of) a gastrostomy tube (a tube placed through the abdomen to facilitate nourishment and medications for residents incapacitated in regards to cognitive status and swallowing), which included ativan (anti-anxiety) 0.5 mg (milligrams).</p> <p>Resident #1's record was reviewed on 08/28/12 at 4:00 p.m. Resident #1 was admitted to the facility on 01/11/11 with diagnoses including, but not limited to, dysphasia (difficulty swallowing), epilepsy, anxiety, profound intellect disability and depressive disorder.</p>	F0333	F3331. Resident #1 has her medication orders reviewed and revised as needed. The physician has been notified of the error in medication administration and the resident has shown no ill effects from this. 2. The Director of Nursing, or her designee, and/or the Pharmacy Nurse Consultant have reviewed the Medication Administration Records and the medication in the medication carts to compare and assure correct doses and routes of administration are in place. 3. The Staff Development Coordinator or designee will in-service the licensed staff on the provision of pharmacy services including following physician orders to include giving the correct dose of medication and correct route of administration. The Staff Development Coordinator will include information on the provision of pharmacy services including following physician orders to include giving the correct dose of medication and correct route of administration to licensed staff in orientation for appropriate new hires. 4. The Director of Nursing, or her designee, will review new medication orders on a weekly basis to assure medications are	09/29/2012			

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	<p>Review of the Physician's Order Sheet, dated 08/2012, indicated: "10/31/2011 ATIVAN (LORAZEPAM) 0.5 MG SL (Sub Lingual: under the tongue) TID (3 times a day) ANXIETY/AGITATION"</p> <p>Review of the MAR (Medication Administration Sheet), dated 08/2012, indicated: "10/31/2011 ATIVAN (LORAZEPAM) 0.5 MG SL (Sub Lingual: under the tongue) TID (3 times a day) ANXIETY/AGITATION"</p> <p>The Facility RN Supervisor was interviewed on 08/28/12 at 4:10 p.m. The Supervisor was unaware the order was for sublingual ativan.</p> <p>The DNS (Director Nursing Services) was interviewed on 08/28/12 at 4:15 p.m. The DNS was unaware the order was for sublingual ativan.</p> <p>LPN #28 was interviewed on 08/29/12 at 8:15 a.m., in regards to how Resident #1 received the ordered ativan and indicated the ativan was administered via the resident's gastrostomy tube.</p> <p>Review of a Policy and Procedure, titled, "Medication Administration",</p>		<p>administered according to physician's order, and monthly follow up thereafter. The Pharmacy Consultant will continue to conduct monthly medication reviews and provide a written report to the Director of Nursing for follow through. The results of these audits will be reviewed and analyzed with a subsequent plan of action developed and implemented as indicated at the monthly Performance Improvement Committee Meeting. The PI Committee will review monthly for 6 months. The Administrator is responsible for overall compliance.</p>				

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	<p>revised 08/31/11, and provided by the Administrator on 08/30/12 at 8:50 a.m., indicated: "Preparation to Medication Administration: ...7. Prepare the medication using the five rights of medication administration: a. Right patient, b. Right medication name and strength, c. Right time of administration, d. Right frequency, e. Right route of administration, ..."</p> <p>3.1-48(c)(2)</p>			