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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>155132 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____ | X3) DATE SURVEY COMPLETED<br><br>05/21/2012 |
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| NAME OF PROVIDER OR SUPPLIER<br><br>DANVILLE REGIONAL REHABILITATION | STREET ADDRESS, CITY, STATE, ZIP CODE<br>255 MEADOW DR<br>DANVILLE, IN 46122 |
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| F0000              | <p>This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00107817.</p> <p>Complaint IN00107817 - Unsubstantiated due to lack of evidence.</p> <p>Survey Dates:<br/>May 14, 15, 16, 17, 18, and 21, 2012</p> <p>Facility Number: 000057<br/>Provider Number: 155132<br/>AIM Number: 100266570</p> <p>Survey Team:<br/>Heather Lay, RN - TC<br/>Janet Stanton, RN</p> <p>Census Bed Type:<br/>SNF: 20<br/>SNF/NF: 77<br/>Total: 97</p> <p>Census Payor Type:<br/>Medicare: 17<br/>Medicaid: 2<br/>Other: 78<br/>Total: 97</p> <p>Sample: 20</p> | F0000         |   |                      |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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|                    | <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on May 30, 2012 by Bev Faulkner, RN</p> |               |   |                      |

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| F0221<br>SS=D  | <p>483.13(a)<br/>RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS</p> <p>The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.</p> <p>Based on record review, interview, and observation, the facility failed to maintain an environment free from physical restraints as evidenced by a resident's inability to release a self-release seat belt on command, failed to assess a resident's ability to release a self-release seat belt prior to implementation of the physical restraint device, and failed to follow facility policy and procedure regarding safety devices. The deficient practice affected 1 of 3 residents reviewed with self-release seat belts in a sample of 20 residents reviewed. [Resident #16]</p> <p>Findings include:</p> <p>1. On 5/14/12 at 10:25 A.M., tour was initiated with Registered Nurse [RN] #4.</p> <p>Resident #16 was identified as non-interviewable with dementia, assisted with activities of daily living, history of falls without injury, and up with assist in a wheelchair with a self-release seat belt in place for safety.</p> <p>On 5/18/12 at 8:55 A.M., Resident #16's</p> | F0221   | <p>Corrective action: a safety assessment and restraint review was completed by the IDT for resident 16. Plan of care updated to reflect current needs. Other residents having the potential to be affected: any resident with a safety device has the potential to be affected. Residents with a safety device will be reviewed, a safety assessment, safety information sheet form will be completed and/or updated. Systematic changes: monthly review of all safety devices will be completed by the IDT and brought to the Systems Review team to ensure correct safety device is in place. Notification will be provided to therapy as determined by the IDT. All self-release safety belts will be added to the MAR's and checked weekly by the nurses to ensure that the resident is being assessed appropriately. Licensed nurses will be re-educated on the safety device program. Monitoring: The Director of Nursing (DON)/designee will monitor during monthly systems review. Unit Managers will monitor MAR's weekly. Safety device/restraints will be brought to monthly QA on an ongoing</p> | 06/20/2012           |   |

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|  | <p>record was reviewed. Diagnoses included, but were not limited to, hypertension, Lewy Body dementia, diabetes mellitus type II, and osteoarthritis.</p> <p>An admission "Minimum Data Set" screening, dated 8/23/11, included, but was not limited to, "Brief Interview Mental Status [BIMS]: 4 [severe cognitive impairment]... transfer: 3/3 [extensive assist of 2 persons]..."</p> <p>A quarterly "Minimum Data Set" screening, dated 4/29/12, included, but was not limited to, "BIMS: 4... transfer: 3/2 [extensive assist of 1 person]..."</p> <p>There was no documentation regarding restraints on either Minimum Data Set.</p> <p>On 5/18/12 at 11:20 A.M., Resident #16 was observed in his wheelchair with a Velcro seatbelt attached to the wheelchair and secured around Resident #16's waist.</p> <p>At that time, in an interview, RN #12 indicated Resident #16 was able to remove the Velcro seat belt on command. RN #12 was requested to ask Resident #16 to remove his seat belt without any cueing.</p> <p>Resident #16 was observed from 11:20</p> |   | <p>basis. Identified non-compliance will result in 1:1 re-education with repeat non-compliance resulting in disciplinary action per policy. Date of completion: 6-20-12</p> |                      |   |

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|                    | <p>A.M. to 11:28 A.M., trying to release his seat belt on command from RN #12. Resident #16 was unable to release his seat belt without cueing from RN #12.</p> <p>At 11:28 A.M., RN #12 was observed taking Resident #16's left hand and placing on his seat belt. She then instructed Resident #16 to use both hands to open his seat belt. At that time, Resident #16 was able to release his seat belt with assistance from RN #12.</p> <p>During record review, the initial assessment prior to application of a self-releasing seat belt was not found in Resident #16's clinical record.</p> <p>On 5/18/12 at 3:00 P.M., Resident #16's initial assessment, subsequent assessments and documentation regarding staff assessment and release of Resident #16's seat belt were requested from the Administrator and Director of Nursing [DoN].</p> <p>On 5/21/12 at 9:30 A.M., the Administrator provided an "OT [Occupational Therapy] Progress Notes," dated 8/17/11, and a "Safety Device Data Collection," dated 5/17/12. The Administrator was unable to provide the original order from the M.D. for the self-releasing seat belt.</p> |               |   |                      |

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|                    | <p>The "OT Progress Notes" included, but was not limited to, "Skilled Service Provided since Last Report: Patient [Resident #16] has demoed [sic] increased alertness and increased participation with OT activities... Patient has had lap belt added to wheelchair this week to decrease fall risk... Patient continues to demo very impulsive behaviors and hallucinations which cause high risk of falls..."</p> <p>There was no information regarding Resident #16's ability to remove the lap belt or Velcro seatbelt.</p> <p>The "Safety Device Data Collection" included, but was not limited to, "Type of Safety Device: Self-releasing lap belt while in wheelchair... Can easily remove: Yes... Is cognitively aware of: Yes... Is the Safety Device a restraining safety device: No... Safety Device Reduction Plan: Staff to release self-releasing alarm belt when resident up in wheelchair every 2 hours and PRN [as needed] [date added to document was 5/18/12, no time]..."</p> <p>On 5/21/12 at 1:30 P.M., the DoN provided a "Medication Administration Record" dated 5/1/12 through 5/31/12.</p> <p>The "MAR" indicated Resident #16's</p> |               |   |                      |

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|  | <p>self-release seat belt was being checked each shift, not every 2 hours as indicated on the "Safety Device Data Collection" document.</p> <p>On 5/17/12 at 4:20 P.M., the facility policy and procedure regarding restraints was requested from the Administrator and DoN.</p> <p>On 5/18/12 at 9:15 A.M., the "Safety Device Application" policy and procedure, dated 1/2009 was received from the Administrator and DoN.</p> <p>The "Safety Device Application" policy and procedure, included, but was not limited to, "Policy: A resident must be thoroughly evaluated for use of safety devices by the Interdisciplinary Team [IDT]... Procedure: Check and release restraining safety device at least every 2 hours and PRN..."</p> <p>On 5/18/12 at 3:00 P.M., in an interview, the Administrator clarified that the above policy and procedure was the only one used for both physical restraints and all other safety devices, such as self-release lap belts or seat belts.</p> <p>3.1-3(w)<br/>3.1-26(b)<br/>3.1-26(h)</p> |   |   |  |  |   |  |

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| F0223<br>SS=A  | <p>483.13(b), 483.13(b)(1)(i)<br/>FREE FROM ABUSE/INVOLUNTARY SECLUSION</p> <p>The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.</p> <p>The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion.</p> <p>Based on record review and interview, the facility failed to prevent the physical abuse of a resident from a Certified Nursing Assistant [CNA #7]. The deficient practice affected 1 of 3 residents reviewed for the Abuse Prohibition Protocol in a sample of 20 residents reviewed. [Resident #21]</p> <p>Findings include:</p> <p>On 5/14/12 at 1:00 P.M., the Administrator provided the facility abuse investigation for Resident #21. The incident was reported to ISDH per abuse policy and procedure and the CNA [#7] was terminated following the facility abuse investigation.</p> <p>The abuse investigation included, but was not limited to, "Incident Date/Time: 3/15/12 at 9:00 P.M....Brief Description of Incident: RN [Registered Nurse #13] entered resident [#21] room and saw that the resident was resisting care... RN [#13]</p> | F0223   | <p>Corrective Action: the incident was reported to the ISDH. The CNA was suspended pending an investigation and received disciplinary action per policy. Other resident having the potential to be affected: No other residents were affected. Other residents assigned to the CNA were interviewed/assessed. No negative outcomes identified. Systematic Changes: The facility will continue to follow ISDH and facility abuse protocol. Staff will be re-educated on abuse protocol and reporting. Abuse protocol and notification will continue to be covered during orientation for all new hires by the Social Service Director (SSD) and/or Admn or designee. Abuse protocol and notification re-education will be provided quarterly on an ongoing basis. Monitoring: The Administrator (Admn)/designee will monitor all staff re-education and orientation to ensure effective abuse protocol training is in place. Admn/designee will randomly validate abuse protocol</p> | 06/20/2012           |   |

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|  | <p>witnessed CNA [#7] make contact with the resident's leg with her open hand... When CNA [#7] turned around, she noticed the RN [#13] and apologized asking her not to say anything... Immediate Action Taken: RN [#13] removed CNA [#7] from situation and contacted the Unit Manager... Preventative Measures Taken: CNA [#7] removed from situation, sent home, and suspended pending an investigation... Administrator spoke with the RN [#13] to ensure resident doing okay... Social Service and Administrator interviewed the resident separately on morning of 3/16/12... Resident [#21] did not have recollection of the event that occurred on 3/15/12...."</p> <p>On 5/16/12 at 1:30 P.M., Resident #21's record was reviewed. Diagnoses included, but were not limited to, depression and osteoarthritis.</p> <p>A quarterly "Minimum Data Set" screening, dated 3/12/12, included, but was not limited to, "Brief Interview Mental Status [BIMS] 5 [severe cognitive impairment]..."</p> <p>3.1-27(a)(1)</p> |   | <p>through 1:1 questioning weekly 2-3 staff x 4 weeks then monthly x 2. Identified trends will be brought to monthly QA on an ongoing basis unless otherwise determined by the QA committee. Identified non-compliance will result in 1:1 re-education with repeat non-compliance resulting in disciplinary action per policy. Date of completion: 6-20-12</p> |  |  |   |  |

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| F0225<br>SS=D      | <p>483.13(c)(1)(ii)-(iii), (c)(2) - (4)<br/>INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>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 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 report an injury of</p> | F0225         | A thorough investigation was completed by the DON and it was determined that the bruising had                   | 06/20/2012           |

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|  | <p>unknown origin to the state agencies and the facility failed to thoroughly investigate an injury of unknown origin. The deficient practice affected 1 of 7 residents reviewed for bruising in a sample of 20 residents reviewed. [Resident #54]</p> <p>Findings include:</p> <p>1. On 5/14/12 at 10:25 A.M., tour was initiated with Registered Nurse [RN] #4.</p> <p>Resident #54 was identified as non-interviewable and required total assistance with care.</p> <p>On 5/15/12 at 2:05 P.M., Resident #54's record was reviewed. Diagnoses included, but were not limited to, dementia, hypertension, depression, osteoporosis, and anemia.</p> <p>A quarterly "Minimum Data Set" screening, dated 3/22/12, included, but was not limited to, "Brief Interview Mental Status [BIMS]: no score [unable to complete]... Transfer: 4/3 [extensive assist of 2 or more persons]..."</p> <p>A "Nurse's Progress Notes," dated 12/13/11 at 12:50 A.M., included, but was not limited to, "Right arm with large dark purple bruising from shoulder to halfway</p> |   | <p>spread down the residents arm and was not a new area of an unknown origin. The MD evaluated area on 12/13/11 and documented "the bruising still of entire arm and half of forearm but torso has healed." The progress note was provided to the surveyor. Corrective action: Resident 54 initial report was sent to ISDH on 12-4-12. Further information related to the bruising was reported on 5-16-12 with review by surveyor. Careplan reviewed to reflect current status. Other residents having the potential to be affected: If an event meeting the definition of an unknown origin is identified, it will be reported to the DON and/or Admn and an investigation will be initiated. Residents residing in the facility will be addressed by following policy and procedure, re-education and/or disciplinary action of employees will result if policy and procedure is not followed. Systematic Changes: Nursing staff will be re-educated on reporting injuries of unknown origin, completion of accident/incident report and informing the DON/Admn. Injuries of unknown origin will be reported per facility and ISDH guidelines. Monitoring: DON and/or designee will monitor accidents/incidents to ensure investigation process is followed per policy/procedure and timely reporting and notification process (per ISDH and facility</p> |  |  |   |  |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                     |   | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>155132 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____  |                      | X3) DATE SURVEY COMPLETED<br><br>05/21/2012 |
| NAME OF PROVIDER OR SUPPLIER<br><br>DANVILLE REGIONAL REHABILITATION |   |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br>255 MEADOW DR<br>DANVILLE, IN 46122  |                      |   |
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|  | <p>down lower arm... complains of pain when upper arm touched... Unit Manager called... 1:45 A.M....[M.D.] called and new order received... X-ray right arm from shoulder to wrist in A.M...."</p> <p>An "M.D. Visit," dated 12/13/11, no time given, included, but was not limited to, "Chief Complaint: Bruising and pain... History of Present Illness: Pain, unable to give history related to dementia, staff noted bruising... staff unsure as to origin/cause... bruising entire arm and half of forearm... Bruising/Hematoma right upper extremity: New Problem... will get X-ray to rule out underlying injury..."</p> <p>On 5/15/12 at 4:20 P.M., the facility incident reporting to ISDH and the investigation of the bruising on 12/13/11 was requested from the Administrator and DoN.</p> <p>On 5/16/12 at 8:45 A.M., in an interview, the DoN indicated the bruising [injury of unknown origin] was not investigated or reported to ISDH because she assumed the bruising was just a continuation from bruising that was investigated and reported to ISDH on 12/4/11. However, the M.D. visit note as well as the Nurse's progress notes indicated the bruising was new or a change in condition.</p> |   | <p>policy and procedure) Identified trends will be reviewed at monthly QA x 3 months then quarterly thereafter (ongoing) to determine if further education and/or monitoring is needed. Identified non-compliance will result in 1:1 education and/or disciplinary action per policy. Identified trends will be brought to the Admn. for review and brought to monthly QA on an ongoing basis (education initiated as needed).Date of completion: 6-20-12</p> |                      |   |

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|                    | <p>On 5/16/12 at 3:00 P.M., an "Accident/Incident Report," dated 12/13/11 at 12:30 A.M., was received from the Administrator and DoN.</p> <p>The "Accident/Incident Report," dated 12/13/11 at 12:30 A.M., included, but was not limited to, "Date of Incident: 12/13/11... Time of Incident: 12:30 A.M.... Unwitnessed... Describe Injury and Exactly What Occurred: CNA [#1] called this writer [RN #3] to room and showed this writer right upper arm and lower right arm with dark purple bruise and some edema to upper arm near axilla [armpit]..."</p> <p>3.1-28(c)</p> |               |   |                      |

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| F0226<br>SS=D  | <p>483.13(c)<br/>DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>Based on record review and interview, the facility failed to ensure their Abuse Prohibition Policies were followed related to reporting an injury of unknown origin or source to the State agencies and failure to investigate potential abuse. The deficient practice affected 1 of 7 resident's reviewed for bruising in a sample of 20 residents reviewed.</p> <p>Findings include:</p> <p>1. On 5/14/12 at 10:25 A.M., tour was initiated with Registered Nurse [RN] #4.</p> <p>Resident #54 was identified as non-interviewable and required total assistance with care.</p> <p>On 5/15/12 at 2:05 P.M., Resident #54's record was reviewed. Diagnoses included, but were not limited to, dementia, hypertension, depression, osteoporosis, and anemia.</p> <p>A quarterly "Minimum Data Set" screening, dated 3/22/12, included, but</p> | F0226   | <p>A thorough investigation was completed by the DON and it was determined that the bruising had spread down the residents arm and was not a new area of an unknown origin. The DON did not state that it was "assumed" that the bruise had spread, but rather an investigation determined that the bruise had spread. The MD evaluated area on 12/13/11 and documented "the bruising still of entire arm and half of forearm but torso has healed." The progress note did not state new or change in condition as stated in the 2567. The progress note was provided to the surveyor. Corrective action: Resident 54 initial report was sent to ISDH on 12-4-12. Further information related to the bruising was reported on 5-16-12 with review by surveyor. Careplan reviewed to reflect current status. Other residents having the potential to be affected: If an event meeting the definition of an unknown origin is identified, it will be reported to the DON and/or Admn and an investigation will be initiated. Residents residing in the facility will be addressed by following policy and procedure,</p> | 06/20/2012   |  |   |  |

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|  | <p>was not limited to, "Brief Interview Mental Status [BIMS]: no score [unable to complete]... Transfer: 4/3 [extensive assist of 2 or more persons]..."</p> <p>A "Nurse's Progress Notes," dated 12/13/11 at 12:50 A.M., included, but was not limited to, "Right arm with large dark purple bruising from shoulder to halfway down lower arm... complains of pain when upper arm touched... Unit Manager called... 1:45 A.M....[M.D.] called and new order received... X-ray right arm from shoulder to wrist in A.M...."</p> <p>An "M.D. Visit," dated 12/13/11, no time, included, but was not limited to, "Chief Complaint: Bruising and pain... History of Present Illness: Pain, unable to give history related to dementia, staff noted bruising... staff unsure as to origin/cause... bruising entire arm and half of forearm... Bruising/Hematoma right upper extremity: New Problem... will get X-ray to rule out underlying injury..."</p> <p>On 5/15/12 at 4:20 P.M., the facility incident reporting to ISDH and the investigation of the bruising on 12/13/11 was requested from the Administrator and DoN.</p> <p>On 5/16/12 at 8:45 A.M., in an interview, the DoN indicated the bruising [injury of</p> |   | <p>re-education and/or disciplinary action of employees will result if policy and procedure is not followed. Systematic Changes: Nursing staff will be re-educated on reporting injuries of unknown origin, completion of accident/incident report and informing the DON/Admn. Injuries of unknown origin will be reported per facility and ISDH guidelines. Monitoring: DON and/or designee will monitor accidents/incidents to ensure investigation process is followed per policy/procedure and timely reporting and notification process (per ISDH and facility policy and procedure) Identified trends will be reviewed at monthly QA x 3 months then quarterly thereafter (ongoing) to determine if further education and/or monitoring is needed. Identified non-compliance will result in 1:1 education and/or disciplinary action per policy. Identified trends will be brought to the Admn. for review and brought to monthly QA on an ongoing basis (education initiated as needed). Date of completion: 6-20-12</p> |  |  |   |  |

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|  | <p>unknown origin] was not investigated or reported to ISDH because she assumed the bruising was just a continuation from bruising that was investigated and reported to ISDH on 12/4/11. However, the M.D. visit note as well as the Nurse's progress notes indicated the bruising was new or a change in condition.</p> <p>On 5/16/12 at 3:00 P.M., an "Accident/Incident Report," dated 12/13/11 at 12:30 A.M., was received from the Administrator and DoN.</p> <p>The "Accident/Incident Report," dated 12/13/11 at 12:30 A.M., included, but was not limited to, "Date of Incident: 12/13/11... Time of Incident: 12:30 A.M.... Unwitnessed... Describe Injury and Exactly What Occurred: CNA [#1] called this writer [RN #3] to room and showed this writer right upper arm and lower right arm with dark purple bruise and some edema to upper arm near axilla [armpit]..."</p> <p>On 5/14/12 at 10:15 A.M., the facility abuse policies and procedures were requested from the Administrator.</p> <p>On 5/14/12 at 10:30 A.M., the facility abuse policies and procedures, dated 7/10, were received from the Administrator.</p> |   |   |  |  |   |  |

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|                    | <p>The abuse policies and procedures, included, but were not limited to,<br/>"Definitions: Injuries of Unknown Source: The source of the injury was not observed by any person or the resident could not explain the source of injury...<br/>Policy: All allegations that meet the definitions of abuse and substantiated violations will be reported to the state agencies and to all other agencies including the local law enforcement, elder abuse agencies, Adult Protective Services... Investigation: Initiate the "Accidents and Incidents: Report, Investigation, Follow-up and Disposition" procedure..."</p> <p>3.1-28(a)</p> |               |   |                      |

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| F0248<br>SS=E  | <p>483.15(f)(1)<br/>ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES</p> <p>The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.</p> <p>A. Based on observation, record review, and interview, the facility failed to continue to provide individualized activities a resident was assessed for and had documented positive outcomes related to the activities. The deficient practice affected 1 of 4 residents reviewed for activities with a diagnosis of mental retardation in a sample of 20 residents reviewed. [Resident #1]</p> <p>B. Based on interview and record review, the facility failed to provide trips to venues outside of the facility as part of the activity program, for 5 of 13 residents interviewed in a group setting. This deficiency had the potential to affect 50 residents physically capable of participating in an extended trip or outing, of 97 residents currently residing in the facility. [Residents #66, #50, #56, #39, and #46]</p> <p>Findings include:</p> <p>A. 1. On 5/14/12 at 10:25 A.M., tour of</p> | F0248   | <p>Corrective Action: resident 1 was re-assessed for individualized activity needs. Resident careplan updated. Level II reviewed with recommendations updated as needed. Activity progress notes reflect changes and current resident activity status. Outside vendors contacted to establish transportation partnership Other residents having the potential to be affected: no other residents were affected. All residents receiving 1:1 will be re-evaluated/ assessed/updated and the plan of care updated as appropriate. Any resident who can participate in activities outside of the facility have the potential to be affected. Therefore, outside vendors have been contacted for potential transportation arrangements. Systematic changes: Activity Director/Life Enrichment Director (LED) has been re-educated on policy and procedure for addressig residents activity and participation levels. A new 1:1 form has been initiated per company policy and procedure. An aggreement has been reached with with an outside</p> | 06/20/2012           |   |

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|  | <p>the facility was initiated with Registered Nurse #4.</p> <p>Resident #1 was identified during tour as having mental retardation and required total assistance with all activities of daily living.</p> <p>On 5/14/12, during tour, Resident #1 was observed in bed in the fetal position with the sheet over her head. At that time, in an interview, RN #4 indicated that was a normal behavior for the resident. RN #4 indicated she spent most of the day in her room. She indicated Resident #1 got up for meals and was then placed back in her room. RN #4 indicated Resident #1 was never in her wheelchair for more than an hour related to her behaviors.</p> <p>On 5/15/12 at 8:50 A.M., Resident #1's record was reviewed. Diagnoses included, but were not limited to, adult failure to thrive, profound mental retardation, and osteoarthritis.</p> <p>An "OBRA Annual Residential Review [required annually for residents with mental retardation]," dated 7/7/11, no time provided, included, but was not limited to, "[Resident #1] spends most of the day in bed... she is placed in her wheelchair to attend some activities and go to the dining area... [Resident #1] has</p> |   | <p>vendor to provide transportation for monthly outings. Monitoring: The Admn/designee will initial the 1:1 activity book weekly x 1 month, every 2 weeks x 2 months then monthly thereafter (ongoing). Identified trends will be reviewed during monthly QA x 3 and quarterly thereafter (ongoing) to determine further education and/or monitoring needs. Identified trends will be forward to the Admn. for review and presented to QA to determine further educational needs. LED will review resident outings monthly with the Admn. on an ongoing basis. Identified non-compliance will result in 1:1 re-education with repeat non-compliance resulting in disciplinary action per policy. Date of completion: 6-20-12</p> |                      |   |

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|                    | <p>daily sensory stimulation visits that include auditory, cognitive, tactile, and olfactory skills... Activity Pursuit Patterns Care Plan includes responding to 1:1's provided with verbal noise, reaching, eye contact and will attend musical programs... She has sensory stimulation visits three times daily to provide social, visual, and tactile stimulation... She will be read to, talked and interacted with by individual staff... [Resident #1] is brought to activities at the center so she is able to observe and receive social stimulation from others... Recommendations: [Resident #1] continues to benefit from participating in activities that provide sensory stimulation for her... She continues to benefit from social interactions from staff and family talking to her, playing with her, and reading to her..."</p> <p>An "Activity Pursuit Patterns Plan of Care," dated 3/15/12, included, but was not limited to, "Assessment: Activities participation limited by: Needs assist to group programs - attempt to include in musical events... Goal: Will participate: with assistance, in room, and out of room... 1:1 reading chronicle, sensory sound... Interventions: Music: Assist to program and sit with her... look for signs of being upset... try reading short stories and daily chronicle... Assessment:</p> |               |   |                      |

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|                    | <p>Physical function related to diagnosis/condition: Resident with contractures, repetitive motions... Goal: [no documentation]... Intervention: Wheeling in and out of facility by staff or family, sensory videos... Assessment: Other related to diagnosis/condition: Daily sensory visits 3 times per day... Goal: Resident will show appropriate reactions... Intervention: Butterfly mobile, soundscapes, and moonlight..."</p> <p>On 5/15/12 at 4:20 P.M., Resident #1's activity logs were requested from the Administrator and DoN for the last 3 months.</p> <p>At that time, in an interview, the DoN indicated Resident #1 spends all her time in her room. She indicated Resident #1 only gets out of her room for meals, three times per day related to her behaviors and inability to be in a group setting.</p> <p>On 5/16/12 at 9:00 A.M., Resident #1's activity logs for the months of March, April, and May, 2012 were received from the DoN.</p> <p>The "Independent Tracking Log" dated 3/12, did not have activities marked for the dates of 3/4, 3/7, 3/9, 3/10, 3/12, 3/14, 3/15, 3/16, 3/18, 3/19, 3/20, 3/22, 3/24, 3/26, 3/27, 3/30, and 3/31, 2012.</p> |               |   |                      |

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|                    | <p>On the dates with activities for 3/12, the following dates only had one activity per day: 3/1, 3/2, 3/3, 3/6, 3/8, 3/23, 3/25, and 3/29 [Music played in the resident's room via a recorder].</p> <p>The "Independent Tracking Log" dated 4/12, did not have activities marked for the dates of 4/6, 4/7, 4/8, 4/11, 4/13, 4/14, 4/17, 4/19, 4/23. 4/25, 4/27. 4/29, and 4/31, 2012.</p> <p>On the dates with activities for 4/12, the following dates only had one activity per day: 4/1, 4/2, 4/5, 4/12, 4/15, 4/20, 4/21, and 4/28 [Music played in the resident's room via a recorder].</p> <p>The "Independent Tracking Log," dated 5/12, did not have activities marked for the dates of 5/5, 5/6, 5/7, 5/13, and 5/15, 2012.</p> <p>On the dates with activities for 5/12, the following dates only had one activity per day: 5/12 and 5/14 [Music played in the resident's room via a recorder].</p> <p>The facility activity calendar activities for March, April, and May, 2012, included, but were not limited to the following daily activities, "Morning News at 9:45 A.M., Chronicle Review at 10:15 A.M., Monday</p> |               |   |                      |

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|                    | <p>Music [specific to Mondays] at 10:45 A.M., Sing a Long [every other Thursday and Sunday] at 3:30 P.M...."</p> <p>During the months of April and May, 2012, the activity of "Outdoor Sensory at 9:00 A.M., 11:00 A.M., 1:30 P.M., 4:30 P.M., and 7:30 P.M. was added.</p> <p>During the dates of 5/14/12 through 5/17/12, there were no observations of Resident #1 participating in any activity in her room or out of her room.</p> <p>The facility was celebrating "National Nursing Home Week" on 5/14/12 through 5/17/12. The group activities associated with the event included, but were not limited to, "5/15/12 at 2:30 P.M.: Sock Hop [with music], 5/16/12 at 2:30 P.M.: Fair Day Frenzy [with a petting zoo], 5/17/12 at 2:30 P.M.: Lei Looping, and 5/18/12 at 12:30 P.M.: Western Wear Cook Out Celebration.</p> <p>At those times, Resident #1 was observed in her room in bed.</p> <p>On 5/17/12 at 10:50 A.M., in an interview, the Administrator and DoN indicated Resident #1 did not tolerate activities in a group setting and spends the day in her room in bed. The DoN and Administrator further indicated that as</p> |               |   |                      |

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|                    | <p>long as they had been at the facility, Resident #1 did not participate in any activities and she required 1 to 1 observation when up in her chair related to behaviors and the facility did not have the staffing for 1 to 1.</p> <p>On 5/17/12 at 4:20 P.M., documentation of Resident #1's behaviors and clarification regarding the change in Resident #1's activity plan of care was requested related to the discrepancy of Resident #1's daily activities provided versus her current plan of care as observed throughout the week. The Administrator and DoN were notified of the concerns regarding the lack of activities and the observations of the resident in her room all day except for meals on the dates of 5/14/12, 5/15/12, 5/16/12, and 5/17/12.</p> <p>On 5/18/12 no further documentation was obtained as to the change in Resident #1's activities. Resident #1's activity plan of care was not reflective on her current, up to date activity care plan dated 3/15/12.</p> <p>The facility did not provide supporting documentation of Resident #1's behaviors or change in condition that would require the resident to remain in her room, except for meals, without activity intervention as documented on her activity plan of care.</p> |               |   |                      |

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|  | <p>The facility was unable to provide proof of individual activities on the days without documentation.</p> <p>B.1. During the initial orientation tour on 5/14/12, 50 of the 97 residents currently residing in the facility were identified by touring nursing staff as potentially physically able to participate in activities that would require transportation away from the building.</p> <p>In interviews during the group meeting on 5/16/12 at 11:15 A.M., 5 of 13 residents in attendance [Residents #66, #50, #56, #39, and #46] indicated the facility had not provided any trips to places like restaurants, shopping stores/malls, or other entertainment venues of interest to them. Resident #56 indicated there hadn't been an outing or trip in about 1-2 years, and "we used to go every month. I miss going to Wal-Mart and going to restaurants." The other four residents indicated they really would like to go someplace outside of the facility, but had been told "transportation costs too much," "can't do it," or "can't afford it." The residents indicated the Resident Council had been looking into starting a "bus fund," and were still trying to organize some kind of fund-raising activity.</p> <p>The Activity program calendars for January, February, March, April, and May</p> |   |   |                      |   |

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|                    | <p>2012 were reviewed. There was no entry listing a trip to any venue outside of the facility in any of the 5 months.</p> <p>The Resident Council meeting minutes included the following information:</p> <p>February 2, 2012: "Activities--1. Excited about outings beginning... 4. Want to start a bus fund...."</p> <p>April 5, 2012: "Activities-- 1. Residents want a bus... 3. Voting on name for bus fund/start fundraising committee...."</p> <p>May, 2012: "Activities... 7. Ask if corporation will pay for 1/2 of bus for trips...."</p> <p>In an interview on 5/18/12 at 2:05 P.M., the Activity Director indicated she had been in that position for about 6 months. She had not previously been a Director, but had worked as an assistant. The Activity Director indicated there had been a trip to Bob Evans restaurant in March, which was not listed on the calendar, and that another trip to a "50's" restaurant was scheduled for the next week. In the interview, the Activity Director indicated transportation with one company was too expensive, and the facility did not have a facility bus or van for the transportation.</p> |               |   |                      |

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|                    | In an interview on 5/21/12 at 4:00 P.M., the Administrator indicated the facility had experienced problems locating a company in the area that provided the kind of transportation they needed.<br><br>3.1-33(a)<br>3.1-33(b)(3) |               |   |                      |

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| F0278<br>SS=B  | <p>483.20(g) - (j)<br/>ASSESSMENT<br/>ACCURACY/COORDINATION/CERTIFIED<br/>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 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 observation, interview and record review, the facility failed to ensure the Minimum Data Set [M.D.S.] assessment was accurately coded for pain and anticoagulant medication use, for 3 of 20 residents in a sample of 20 residents reviewed. [Residents #57, #59, and #77]</p> <p>Findings include:</p> | F0278   | <p>Corrective action: Resident 57, 59, 77 MDS's have being modified to accurately reflect scheduled pain med, prn pain med, and anticoagulant therapy received Other residents having the potential to be affected: 100% review of current MDS's for active residents have been completed related to scheduled pain med, prn pain med, and</p> | 06/20/2012   |  |   |  |

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|  | <p>1. In an interview during the initial orientation tour on 5/14/12 at 11:00 A.M., R.N. #9 indicated Resident #57 had Stage I pressure sore areas on both buttocks. She indicated staff had difficulty in getting the resident to lay down after meals to take pressure off of the areas, so the resident sat up in her wheelchair for most of the day.</p> <p>On 5/15/12 at 12:45 P.M., the resident was observed in her room sitting in a wheelchair positioned next to her bed. The resident said "My bottom is sore. This wheelchair is uncomfortable to sit in." The resident, and a family member who was present, also indicated she [the resident] had a phobia about laying in bed or sitting in any stationary-type chair.</p> <p>The clinical record for Resident #57 was reviewed on 5/15/12 at 1:25 P.M. Diagnoses included, but were not limited to, history of a C.V.A. [cerebral vascular accident--"stroke"] with hemiplegia [paralysis]; depressive disorder, myalgia and myositis [muscle pain and inflammation]; restless leg syndrome; and history of peripheral vascular disease.</p> <p>An annual M.D.S. assessment was completed on 1/17/12, with the "look-back" period [the Assessment</p> |   | <p>anticoagulant therapy received. Any areas identified will be modified to reflect the residents current status. Systematic changes: CRS has been re-educated on accurately coding for scheduled pain meds, prn pain meds, and anticoagulation therapy received. CRC/designee will review MDS's monthly for accurate coding of scheduled pain meds, prn pain meds, and anticoagulant therapy x 3 months, then 50% of completed MDS's will be reviewed monthly x 3 months. A random audit will continue ongoing for active residents. Monitoring: CRC/designee will review completed MDS's monthly for accurate coding of scheduled pain meds, prn pain meds, and anticoagulant therapy x 3 months, then 50% of completed MDS's will be reviewed monthly x 3 months. A random audit will be completed by the CRC/designee ongoing for active residents unless otherwise determined by the QA team. Identified trends will be reviewed in monthly QA x 3 months then quarterly thereafter (ongoing) unless otherwise determined by the QA team. Identified trends will be forward to the Admn for review and presented to QA to determine further educational needs. Identified non-compliance will result in 1:1 re-education with repeat non-compliance resulting in disciplinary action. Date of</p> |  |  |   |  |

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|                    | <p>Reference Date--A.R.D.] ending on 1/16/12. A quarterly assessment was completed on 3/1/12, with the A.R.D. listed as 2/29/12.</p> <p>The "Pain Management (5-Day Look Back)" section of each M.D.S. assessment indicated the resident had not "been on a scheduled pain medication regimen;" had not "received P.R.N. ["pro re nata"--as needed] pain medications;" and had not "received non-medication interventions for pain."</p> <p>The May, 2012 physician order recap [recapitulation] sheet listed an order, dated 12/18/11, for Tylenol, 325 mg. [milligrams] 2 tablets every 4 hours P.R.N.</p> <p>The January, 2012 M.A.R. [Medication Administration Record] indicated the resident received a dose of the P.R.N. Tylenol on 1/10, 1/11, and 1/13/12. All three doses were administered to the resident within the 5-day "look-back" period from the A.R.D. date of 1/16/12 for the annual M.D.S. assessment.</p> <p>The February, 2012 M.A.R. indicated the resident received a dose of the P.R.N. Tylenol on 2/24, 2/25, 2/26, and 2/28/12. All four doses were administered to the resident within the 5-day "look-back"</p> |               | completion: 6-20-12   |                      |

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|  | <p>period from the A.R.D. date of 2/29/12 for the quarterly M.D.S. assessment.</p> <p>In an interview on 5/17/12 at 10:00 A.M., the M.D.S. Coordinator indicated she was not sure why she had coded this section as she did, and would review it. In an interview on 5/17/12 at 3:30 P.M., the M.D.S. Coordinator indicated she should have coded the P.R.N. medications, but did not because the resident always indicated in her interview that she was not having pain.</p> <p>2. In an interview during the initial orientation tour on 5/14/12 at 11:00 A.M., R.N. #9 indicated Resident #59 was bedfast, had an open pressure sore area of the coccyx for which she utilized a specialized air mattress, and was receiving Hospice agency services. The nurse was not sure if the resident received routine pain medications.</p> <p>The clinical record for Resident #59 was reviewed on 5/16/12 at 2:35 P.M. Diagnoses included, but were not limited to, senile dementia--Alzheimer's type; history of urinary tract infection; cellulitis of the trunk of the body; arthritis; and history of abdominal pain.</p> <p>A Significant Change M.D.S. assessment was completed on 2/15/12, with the</p> |   |   |  |  |   |  |

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|                    | <p>"look-back" period [the Assessment Reference Date--A.R.D.] ending on 2/14/12.</p> <p>The "Pain Management (5-Day Look Back)" section of the M.D.S. assessment indicated the resident had "been on a scheduled pain medication regimen;" had "received P.R.N. ["pro re nata"--as needed] pain medications;" and had not "received non-medication interventions for pain."</p> <p>The May, 2012 physician order recap [recapitulation] sheet listed an order, dated 1/20/12, for Tylenol 325 mg. [milligrams] 2 tablets every 6 hours P.R.N.</p> <p>The February, 2012 M.A.R. [Medication Administration Record] indicated the resident had not received any doses of the P.R.N. Tylenol during the 5-day "look-back" assessment period from 2/9 to 2/14/12.</p> <p>On 3/7/12, the physician gave an order for Hydrocodone/Tylenol 7.5/325 mg. one tablet every 4 hours P.R.N., and on 4/12/12 gave an order to give scheduled doses of the medication as well as the P.R.N. The medication was ordered after the M.D.S. assessment dates.</p> |               |   |                      |

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|                    | <p>In an interview on 5/17/12 at 3:00 P.M., the M.D.S. Coordinator indicated she did not look at the clinical record for information related to pain medications. She relied on the information given during the resident interview about pain.</p> <p>3. In an interview during the initial orientation tour on 5/14/12 at 11:15 A.M., R.N. #9 indicated Resident #77 received Coumadin [an anti-coagulant "blood thinner" medication].</p> <p>The clinical record for Resident #77 was reviewed on 5/18/12 at 10:15 A.M. Diagnoses included, but were not limited to, diabetes, chronic kidney disease, senile dementia, atrial fibrillation, and long-term anticoagulation.</p> <p>An initial M.D.S. assessment was completed on 10/13/11 with the "look-back" period [the Assessment Reference Date--A.R.D.] ending on 10/10/11.</p> <p>The "Medications Received" section of the M.D.S. indicated the resident had received insulin, anti-depressant, and diuretic medications during a 7-day "look back" period from 10/3 to 10/10/11. The category for anti-coagulant medication was not marked.</p> |               |   |                      |

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|                    | <p>A physician's progress note, dated 10/6/11, indicated the resident was receiving a routine dose of Coumadin 9.5 mg. daily.</p> <p>During the daily conference on 5/18/12 at 2:45 P.M., the Director of Nursing was given the opportunity to submit any additional information/evidence related to the correct coding of the "Medications Received" section of the M.D.S. for this resident.</p> <p>At the final exit on 5/21/12 at 4:00 P.M., no additional documentation was provided for review.</p> <p>3.1-31(i)</p> |               |   |                      |

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| F0282<br>SS=D  | <p>483.20(k)(3)(ii)<br/>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 record review, interview, and observation, the facility failed to follow the individualized activity care plan for 1 of 4 residents [Resident #1] reviewed for activities with a diagnosis of mental retardation in a sample of 20 residents reviewed. The facility failed to follow a physician's order for a therapy evaluation of a leg brace in 1 of 1 resident [Resident #85] reviewed for a therapy evaluation in a sample of 20 residents reviewed.</p> <p>Findings include:</p> <p>1. On 5/14/12 at 10:25 A.M., tour of the facility was initiated with Registered Nurse #4.</p> <p>Resident #1 was identified during tour as having mental retardation and required total assistance with all activities of daily living.</p> <p>On 5/14/12, during tour, Resident #1 was observed in bed in the fetal position with the sheet over her head. At that time, in an interview, RN #4 indicated that was a normal behavior for the resident. RN #4</p> | F0282   | <p>Corrective Action: resident 1 careplan reviewed and updated to reflect current activity status. Resident 85 no longer resides in the facility. Other residents having the potential to be affected: All MR/DD careplans have been audited and evaluated. No other MR/DD careplans were affected. However, the LED and Social Service Director (SSD)/QMRP will review all MR/DD careplans for accuracy and provide changes as necessary. A progress note will be added either to the activity or social service section of the medical chart in regard to the review/changes. At the time of the plan of correction, there are no other residents residing in the facility who have a leg brace. Systematic changes: SSD/QMRP will provide documentation on Level II follow up/discrepancies to reflect current activity/level of function or residents with diagnosis of MR/DD. The careplan will be updated as appropriate. Activity/level of function of each MR/DD resident will be reviewed upon each assessment reference date and updated as appropriate, ongoing. Daily orders will be reviewed during daily (excluding</p> | 06/20/2012           |   |

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|  | <p>indicated Resident #1 stays in her room and only was placed in her wheelchair for meals, three times per day. RN #4 indicated Resident #1 was never in her wheelchair for more than 1 hour at a time related to behaviors.</p> <p>On 5/15/12 at 8:50 A.M., Resident #1's record was reviewed. Diagnoses included, but were not limited to, adult failure to thrive, profound mental retardation, and osteoarthritis.</p> <p>An "Activity Pursuit Patterns Plan of Care," dated 3/15/12, included, but was not limited to, "Assessment: Activities participation limited by: Needs assist to group programs - attempt to include in musical events... Goal: Will participate: with assistance, in room, and out of room... 1:1 reading chronicle, sensory sound... Interventions: Music: Assist to program and sit with her... look for signs of being upset... try reading short stories and daily chronicle... Assessment: Physical function related to diagnosis/condition: Resident with contractures, repetitive motions... Goal: [no documentation]... Intervention: Wheeling in and out of facility by staff or family, sensory videos... Assessment: Other related to diagnosis/condition: Daily sensory visits 3 times per day... Goal: Resident will show appropriate</p> |   | <p>weekends and holidays) at clinical triage with any therapy order provided to the Facility Rehab Coordinator (FRC)/FRC designee. A communication box will be provided by the therapy door for therapy communication. Re-education will be provided to licensed nurses and the therapy team regarding therapy orders and communication. Monitoring: Identified trends will be reviewed in QA monthly x 3 months then quarterly thereafter (ongoing) to determine education and monitoring needs. Identified non-compliance will result in 1:1 re-education and addressed as appropriate by the DON and/or Admn. Identified trends will be forward to the Admn for review and presented to QA (ongoing) to determine further education needs. Identified non-compliance will result in 1:1 re-education with repeat non-compliance resulting in disciplinary action per policy. Date of completion: 6-20-12</p> |  |  |   |  |

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|                    | <p>reactions... Intervention: Butterfly mobile, soundscapes, and moonlight..."</p> <p>On 5/15/12 at 4:20 P.M., Resident #1's activity logs were requested from the Administrator and DoN for the last 3 months.</p> <p>At that time, in an interview, the DoN indicated Resident #1 spends all her time in her room. She indicated Resident #1 only gets out of her room for meals, three times per day related to her behaviors and inability to be in a group setting.</p> <p>On 5/16/12 at 9:00 A.M., Resident #1's activity logs for the months of March, April, and May, 2012 were received from the DoN.</p> <p>The "Independent Tracking Log," dated 3/12, did not have activities marked for the dates of 3/4, 3/7, 3/9, 3/10, 3/12, 3/14, 3/15, 3/16, 3/18, 3/19, 3/20, 3/22, 3/24, 3/26, 3/27, 3/30, and 3/31, 2012.</p> <p>On the dates with activities for 3/12, the following dates only had one activity per day: 3/1, 3/2, 3/3, 3/6, 3/8, 3/23, 3/25, and 3/29.</p> <p>The "Independent Tracking Log," dated 4/12, did not have activities marked for the dates of 4/6, 4/7, 4/8, 4/11, 4/13, 4/14,</p> |               |   |                      |

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|  | <p>4/17, 4/19, 4/23. 4/25, 4/27. 4/29, and 4/31, 2012.</p> <p>On the dates with activities for 4/12, the following dates only had one activity per day: 4/1, 4/2, 4/5, 4/12, 4/15, 4/20, 4/21, and 4/28.</p> <p>The "Independent Tracking Log," dated 5/12, did not have activities marked for the dates of 5/5, 5/6, 5/7, 5/13, and 5/15, 2012.</p> <p>On the dates with activities for 5/12, the following dates only had one activity per day: 5/12 and 5/14.</p> <p>The facility activity calendar activities for March, April, and May, 2012, included, but were not limited to the following daily activities, "Morning News at 9:45 A.M., Chronicle Review at 10:15 A.M., Monday Music [specific to Mondays] at 10:45 A.M., Sing a Long [every other Thursday and Sunday] at 3:30 P.M...."</p> <p>During the months of April and May, 2012, the activity of "Outdoor Sensory at 9:00 A.M., 11:00 A.M., 1:30 P.M., 4:30 P.M., and 7:30 P.M. was added.</p> <p>During the dates of 5/14/12 through 5/17/12, there were no observations of Resident #1 participating in any activity</p> |   |   |  |  |   |  |

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|                    | <p>in her room or out of her room.</p> <p>On 5/17/12 at 10:50 A.M., in an interview, the DoN indicated she has never known Resident #1 to participate in activities related to her behaviors and mental state. The DoN indicated when Resident #1 is up in her wheelchair, she requires 1 to 1 care and the facility does not have the staffing to have someone with her 1 to 1 except for meals.</p> <p>On 5/17/12 at 4:20 P.M., documentation of Resident #1's behaviors was requested from the Administrator and DoN and further clarification of the activities of daily activity interventions offered to Resident #1.</p> <p>On 5/18/12 no further documentation or clarification was given as to the lack of interventions provided by the facility or any change in Resident #1's activity interventions related to behaviors as suggested by the Administrator and Don on 5/17/12.</p> <p>The facility provided daily activities to meet care planned needs of Resident #1; however, Resident #1 was not included in those activities. The facility failed to meet the activity needs of Resident #1.</p> <p>2. In an interview during the initial</p> |               |   |                      |

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|  | <p>orientation tour on 5/14/12 at 10:25 A.M., L.P.N. #10 indicated Resident #85 had sustained a fall with a fracture at home, and was in the facility for therapy. She indicated the resident wore a special knee and leg brace.</p> <p>The clinical record for Resident #85 was reviewed on 5/14/12 at 1:55 P.M. Diagnoses included, but were not limited to, aftercare--traumatic supracondyl hip fracture, vertigo, and osteoarthritis.</p> <p>On 4/18/12, the physician ordered "Right knee immobilizer and walker at all times;" and "No weight bearing on right lower extremity."</p> <p>A Nurse's Note, dated 5/1/12 at 6:20 P.M., indicated "... Family noticed sore area above right ankle--9 cm. [centimeters] above right ankle 3 by 1.5 cm. Area red and inflamed. Called physician who ordered brace removed tonight. Have therapy re-eval brace placement tomorrow."</p> <p>A physician's phone order, with no date but timed at 6:00 P.M., indicated "Remove brace tonight 5/1/12. Use fracture pan for toilet. Have therapy re-eval for brace placement."</p> <p>The only Nurse's Note for 5/2/12 was</p> |   |   |                      |   |

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|                    | <p>timed at 9:00 P.M., and did not contain any information related to the brace or therapy having re-evaluated it. There was no subsequent documentation about any reddened area.</p> <p>The next Nurse's Note was dated 5/3/12 at 6:50 P.M. and indicated "... Leg brace in place..." There was no documentation related to the brace having been re-evaluated by therapy on that date, or information about any reddened area.</p> <p>A physician's order, dated 5/8/12, indicated "1.) Did we get brace fixed?...."</p> <p>During the daily conference on 5/15/12 at 4:30 P.M., the Director of Nursing was given the opportunity to submit any therapy progress notes or other evidence/documentation that the resident's brace had been re-evaluated by therapy.</p> <p>In an interview during the daily conference on 5/17/12 at 4:15 P.M., the Director of Nursing indicated she was pretty sure therapy had looked at the brace, and had some progress notes from the therapy department.</p> <p>On 5/18/12, the Director of Nursing provided copies of progress notes from the Occupational Therapy Department,</p> |               |   |                      |

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|                    | <p>which had the following information:</p> <p>The last therapy note for 5/1/12 was entered at 3:14 P.M., prior to the Nurse's Note at 6:20 P.M., and indicated "Educated resident in donning/doffing new brace and placement to max positioning for comfort and shortened strap for better fit due to petite frame."</p> <p>Therapy notes on 5/2/12 were entered at 3:13 P.M., and did not address re-evaluation of the brace.</p> <p>Therapy notes on 5/3/12 and 5/4/12 did not address re-evaluation of the brace.</p> <p>3.1-35(g)(2)</p> |               |   |                      |

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| F0323<br>SS=G  | <p>483.25(h)<br/>FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES<br/>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.</p> <p>A. Based on record review and interview, the facility failed to prevent an avoidable accident related to improper transfer of a resident [Resident #54] using a Hoyer lift [mechanical lift] causing extensive bruising 1 of 7 residents reviewed for bruising in a sample of 20 residents reviewed.</p> <p>B. Based on record review and interview, the facility failed to monitor the functioning of a personal alarm for a resident [Resident #13] with a history of falls. The deficient practice affected 1 of 2 residents reviewed with self-release alarmed belts.</p> <p>Findings include:</p> <p>A. 1. On 5/14/12 at 10:25 A.M., tour was initiated with Registered Nurse [RN] #4.</p> <p>Resident #54 was identified as non-interviewable and required total assistance with care.</p> <p>At that time, the Certified Nursing</p> | F0323   | <p>A thorough investigation was completed by the DON and it was determined that the bruising had spread down the residents arm and was not a new area of an unknown origin. The MD evaluated area on 12/13/11 and documented "the bruising still of entire arm and half of forearm but torso has healed." The progress note was provided to the surveyor. Corrective action: Resident 54 initial incident reported on 12-4-11. Further information related to the bruising was reported on 5-16-12 with review by the surveyor. A hoyer lift in-service was provided at the time of the event for nursing personnel with review by the surveyor. Resident 13 safety device was re-assessed and removed. Resident 54 and 13 careplans reviewed to reflect current status. Other residents having the potential to be affected: All safety devices will be reviewed by the IDT, a safety assessment, safety information form will be completed as appropriate. 1:1 re-education will be provided and/or disciplinary action of employees will result if policy and procedure is not</p> | 06/20/2012   |  |   |  |

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|  | <p>Assistant [CNA] Assignment Sheet for Resident #54 was requested from RN #4 and received at 11:00 A.M. In an interview, RN #4 indicated the sheet was the most current.</p> <p>The CNA Assignment Sheet indicated Resident #54 was a total assist with all activities of daily living and required the use of a Hoyer [mechanical] lift with 2 person assist with transfers.</p> <p>On 5/14/12 at 11:00 A.M., the Administrator provided an abuse investigation for Resident #54 for the Abuse Prohibition Protocol.</p> <p>The facility abuse investigation included, but was not limited to the following information:</p> <p>A "Fax/Incident Report," dated with incident date 12/4/11 at 4:00 A.M., included, but was not limited to, "Brief Description of Incident: During ADL [activities of daily living] care Certified Nursing Assistant [CNA] # 1 noted bruise to resident's [Resident #54] right breast and back measuring 19 centimeters by 8 centimeters... Immediate Action Taken: Assessed rest of body no other area identified, pain assessment completed, Director of Nursing [DoN], family, and M.D. notified... ongoing investigation</p> |   | <p>followed. Systematic changes: A hoier lift re-education will be provided to nursing personnel. Instructions on how to use the hoier lift will be attached to each hoier lift for reference. Re-education will be provided to the IDT to review the safety device policy/program, safety device assessments and safety device release. The self-release belts will be added to the MAR's to check the residents ability to self release weekly. Monitoring: Identified trends will be reviewed monthly at QA x 3 months then quarterly thereafter (ongoing) to determine if further education and/or monitoring is needed. Identified non-compliance will result in 1:1 education and/or employee addressed as appropriate. Identified trends will be forward to the Admn for review and presented to QA to determine further educational needs (ongoing) Date of completion: 6-20-12</p> |                      |   |

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|  | <p>continues... Preventative Measures Taken:<br/>In-servicing CNA's and Nursing on the use of the Hoyer lifts and the proper use of slings with a return demonstrations...<br/>Nursing will be able to identify improper use of hoyer sling..."</p> <p>A "Incident of Unknown Origin," dated 12/4/11 at 4:00 A.M., included, but was not limited to, "Any environmental factors/resident habits that may have caused injury? Transfers with Hoyer lift and assist of one [should have been 2 staff transferring with the mechanical lift]...<br/>Factors that may have caused the incident: Resident [#54] is transferred with a Hoyer lift... Nursing identified staff member [CNA #8] using Hoyer pad incorrectly..."</p> <p>A written statement from RN #3, dated 12/5/11, no time, included, but was not limited to, "Observed [CNA #8] transferring [Resident #54] with the Hoyer lift... did not look appropriate for resident... hand grips appear on bottom instead of top of sling [had sling upside down] sling looked too small... straps cutting into [resident] arms..."</p> <p>On 5/15/12 at 2:05 P.M., Resident #54's record was reviewed. Diagnoses included, but were not limited to, dementia, hypertension, depression, osteoporosis, and anemia.</p> |  |  |  |
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|  | <p>A quarterly "Minimum Data Set" screening, dated 3/22/12, included, but was not limited to, "Brief Interview Mental Status [BIMS]: no score [unable to complete]... Transfer: 4/3 [extensive assist of 2 or more persons..."</p> <p>On 5/15/12 at 4:20 P.M., the policy and procedure on the Hoyer lift and the manufacturer's guide for the Hoyer lift was requested from the Administrator and DoN.</p> <p>On 5/16/12 at 8:45 A.M., the "Mechanical Lift" policy and procedure, dated 1/11, and the manufacturer's guide for the "Manual/Electric Portable Patient Lift," dated 2011, was received from the DoN.</p> <p>The policy and procedure included, but was not limited to, "Verify that staff is aware of the proper procedures and the manufacturer's instructions for equipment use..."</p> <p>The "Manual/Electric Portable Patient Lift" included, but was not limited to, "Warning: Although Invacare recommends that two assistants be used for all lifting preparation, transferring from and transferring to procedures, our equipment will permit proper operation by one assistant... The use of one assistant</p> |   |   |  |  |   |  |

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|                    | <p>is based on the evaluation of the health care professional for each individual case..."</p> <p>B.1. On 5/14/12 during the initial tour of the facility, Resident #13 was identified as non-interviewable, having mental retardation, history of falls, and utilizing a self-release seat belt while up in wheelchair for fall prevention.</p> <p>At 10:45 A.M., during the initial tour, Resident #13 was observed in his room at the bedside releasing his self-release belt, and standing to retrieve a personal item off his bed. At that time, his personal alarm started sounding and RN #4 immediately checked on the resident without incident.</p> <p>On 5/17/12 at 1:10 P.M., Resident #13's record was reviewed. Diagnoses included, but were not limited to, Cerebral Palsy, moderate mental retardation, convulsions, and seizure disorder.</p> <p>A "Nurse's Progress Notes," dated 4/23/12, no time, indicated Resident #13 fell getting out of bed to his wheelchair as the wheelchair brakes were not locked.</p> <p>On 5/17/12 at 1:20 P.M., in an interview, LPN #6 indicated Resident #13 could</p> |               |   |                      |

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|                    | <p>release his self-release seat belt without any difficulty. At that time, LPN #6 instructed the resident to release his seat belt on command. Resident #13 was observed to move the seat belt without difficulty or cueing. However, upon removal of the seat belt, the alarm did not sound.</p> <p>At that time, in an interview, LPN #6 indicated the resident broke his alarm and had a history of either turning it off or breaking it. She indicated she would replace his alarm.</p> <p>On 5/17/12 at 1:25 P.M., the daily function check for Resident #13's personal alarm was requested. LPN #6 could not find the documentation in the chart and indicated the function was to be checked each shift.</p> <p>On 5/17/12 at 1:30 P.M., in an interview, RN #4 indicated Resident #13's self-release seat belt should be checked and documented each shift. RN #4 was unable to locate the documentation for the personal alarm function check.</p> <p>On 5/18 12 at 3:00 P.M., the documentation of Resident #13's personal alarm function was requested from the Administrator and DoN.</p> |               |   |                      |

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|  | <p>On 5/21/12, the Administrator and DoN were unable to provide the requested documentation for Resident #13's personal alarm function checks each shift.</p> <p>3.1-45(a)(2)</p> |   |   |                      |   |

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| F0371<br>SS=F  | <p>483.35(i)<br/>FOOD PROCURE,<br/>STORE/PREPARE/SERVE - SANITARY<br/>The facility must -<br/>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and<br/>(2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>Based on observation, interview, and record review, the facility failed to maintain potentially hazardous food at a cold holding temperature at or less than 40 degrees Fahrenheit, in 1 of 1 main kitchen. This deficiency had the potential to impact 92 of 92 residents who received meals from the main kitchen.</p> <p>Findings include:</p> <p>During the initial kitchen observation task on 5/14/12 at 10:00 A.M., with the Dietary Manager in attendance, the following was observed:</p> <p>Walk-In Refrigerator: A large, 6-inch deep metal pan was covered tightly with aluminum foil. The Dietary Manager identified the contents as a tuna pasta salad that had been prepared "last evening" [Sunday, 5/13/12], and was to be served at today's lunch meal [Monday, 5/14/12]. The Dietary Manager obtained a thermometer from one of the cooks, and checked the temperature of the food. At</p> | F0371   | <p>Upon the initial tour with the surveyor, the Dietary Manager (DM) communicated that the refrigerator may have been down and we had contacted the refrigeration vendor to assess and repair as needed. The food mentioned in the 2567 was tested during the initial tour. The DM later notified the surveyor that the refrigerator was repaired, the food items mentioned were thrown out and not served to the residents and that the items were remade Neither surveyor returned to the kitchen. The DM tested each food item in the refrigerator to ensure that all items were within the correct temperature perimeters and discarded items that did not meet the regulatory guidelines. Upon survey exit, the Admn asked the surveyor if either had returned to the kitchen to follow up, the response was no. Prior to exiting, the Admn communicated to the surveyors that the refrigerator had been repaired, all food items affected had been discarded, new items prepared and temperatures were taken to ensure items were served at the proper</p> | 06/20/2012   |  |   |  |

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|  | <p>the side of the pan, the temperature first registered 50 degrees, then went down to 49 degrees. She repositioned the thermometer in the center of the food, and obtained a temperature of 55 degrees. She indicated the food would have to be discarded and an more made to serve at the lunch meal.</p> <p>Two other pans were observed next to the pan with the tuna pasta salad. Both were tightly covered with aluminum foil. The first pan had sliced turkey. The Dietary Manager indicated the turkey had been "used last night" for the Sunday dinner meal. She checked and obtained a temperature of 46.1 degrees. The second pan contained a pea salad. The Dietary Manager indicated this had also been prepared and served the previous day. The temperature obtained was 45 degrees.</p> <p>During an interview on 5/15/12 at 11:45 A.M., the Dietary Manager indicated the walk-in refrigerator "went out" yesterday, and she had to get it fixed.</p> <p>In an interview on 5/16/12 at 2:10 P.M., Dietary Cook #11 indicated she had prepared the tuna pasta salad on Sunday, 5/13/12 at about 4:00 P.M. After fixing the salad, she had placed it in the walk-in refrigerator. At 2 hours, she checked the temperature and it was 69 degrees. In</p> |   | <p>temperature. Corrective action: No residents were affected by this practice as the food was not served and had been discarded. Residents having the potential to be affected: Residents residing in the facility will be addressed by following policy and procedure. 1:1 re-education will be provided and/or disciplinary action of employees will result if policy and procedure is not followed. Systematic Changes: The walk-in refrigerator temperatures will be tested 2x/day. Temperatures for prepped items will be tested at an estimated 2 hours, 4 hours and 6 hours to ensure prepped foods will be served at the appropriate temperature. All prepped items will be checked daily x 1 week then 1 prepped item will be checked daily x 8 weeks. The DM will provide an in-service to all dietary personnel regarding refrigerator and food temperatures. Monitoring: The DM/designee will monitor the refrigerator and food temperatures daily ongoing. The DM/designee will bring results of the refrigerator and food temps to monthly QA x 3 months then quarterly ongoing unless otherwise noted by the QA team. Identified non-compliance will result in re-education with repeat non-compliance resulting in disciplinary action per policy. Identified trends will be forward to</p> |  |  |   |  |

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|  | <p>another 2 hours, she checked the temperature again, and it was 40 degrees. She indicated she had also checked the temperature of the turkey on Sunday, and obtained a temperature of 40 degrees. She had made the pea salad on Sunday, and had gotten a temperature of 38 degrees.</p> <p>The Dietary Cook indicated she remembered the temperatures, but did not keep any logs or documentation of the temperatures.</p> <p>The "Retail Food Establishment Sanitation Requirements" manual, Title 410 IAC 7-24, effective November 13, 2004, includes the following:</p> <p>"Section 187. (a) Except during preparation, cooking, or cooling, or when time is used as the public health control as specified under section 193 of this rule, potentially hazardous food shall be maintained as follows: ... (2) At a temperature specified in the following:<br/>(A) At forty-one (41) degrees Fahrenheit or less....</p> <p>Section 190. (a) Cooling shall be accomplished in accordance with the time and temperature criteria specified under section 189 of this rule by using one (1) or more of the following methods based</p> |   | the Admn for review and presented to QA to determine further educational needs (ongoing).Date of completion: 6-20-12 |                      |   |

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|                    | <p>on the type of food being cooled: (1) Placing the food in shallow pans. (2) Separating the food into smaller or thinner portions... (7) Other effective methods. (b) When placed in cooling or cold holding equipment, food containers in which food is being cooled shall be: (2) loosely covered, or uncovered if protected from overhead contamination...."</p> <p>3.1-21(i)(2)</p> |               |   |                      |

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| F0441<br>SS=D  | <p>483.65<br/>INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program<br/>The facility must establish an Infection Control Program under which it -<br/>(1) Investigates, controls, and prevents infections in the facility;<br/>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and<br/>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection<br/>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.<br/>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.<br/>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens<br/>Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on record review and interview, the facility failed to implement proper hand</p> | F0441   | Corrective action: the nurse was immediately re-educated on   | 06/20/2012           |   |

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|  | <p>washing after changing a resident's dressing covering an open wound. The deficient practice affected 1 of 3 resident's who were observed during dressing changes in a sample of 20 residents reviewed. [Resident #1]</p> <p>Findings include:</p> <p>1. On 5/16/12 at 10:40 A.M., a dressing change by Licensed Practical Nurse [LPN] #6 was observed on Resident #1.</p> <p>The wound was located on Resident #1's left shoulder area. The wound was described as a boil. The area appeared open without drainage. LPN #6 cleansed the area with normal saline, applied Neosporin [topical antibiotic], then covered the wound with a sterile dressing.</p> <p>After the dressing change, LPN #6 removed her gloves and left the resident room without washing her hands.</p> <p>At 10:55 A.M., LPN #6 was observed answering the telephone, still without handwashing. After her telephone call, in an interview, LPN #6 indicated she usually washed her hands after patient care; however, she had to answer a page [telephone call]. She indicated she knew she should wash after performing a dressing change and prior to caring for</p> |   | <p>handwashing and infection control per policy. Resident 1 exhibited no negative outcome. Other residents having the potential to be affected: any resident receiving a dressing change has the potential to be affected, however, this was an isolated incident. A hand-washing/infection control in-service will be provided to nursing personnel. The ETD/designee will check off each nurse following a dressing change to ensure proper hand washing techniques. Systematic Changes: An infection control/hand-washing in-service will be provided for nursing personnel. The licensed nurses will receive additional infection control education specifically related to dressing changes. The ETD/designee will observe at least 2-3 dressing changes/week x 4 weeks and 2-3 dressing changes bi-weekly x 8 weeks. Monitoring: Identified trends will be reviewed in monthly QA x 3 months then quarterly thereafter to determine if further education or monitoring is needed. Identified non-compliance will result in 1:1 re-education with repeat non-compliance resulting in disciplinary action per policy. Any identified trend will be forward to the Admn for review and presented to QA to determine further educational needs (ongoing). Date of completion: 6-20-12</p> |  |  |   |  |

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|                    | <p>other residents.</p> <p>2. On 5/14/12 at 11:00 A.M., the facility "Hand Hygiene" policy and procedure, dated 4/10, was received from the Administrator as part of her entrance documents.</p> <p>The "Hand Hygiene" policy and procedure, included, but was not limited to, "Policy: Hand Hygiene - Plain Soap and Water Handwash: A plain soap and water handwash may also be used... After contact with non-intact skin and wound dressings... after removing gloves..."</p> <p>3.1-18(I)</p> |               |   |                      |

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| F0516<br>SS=F  | <p>483.75(l)(3), 483.20(f)(5)<br/>RELEASE RES INFO, SAFEGUARD CLINICAL RECORDS<br/>A facility may not release information that is resident-identifiable to the public.</p> <p>The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.</p> <p>The facility must safeguard clinical record information against loss, destruction, or unauthorized use.</p> <p>Based on observation and interview, the facility failed to secure medical records from loss, destruction, or unauthorized use in 1 of 1 Medical Records room.</p> <p>Findings include:</p> <p>The environmental tour was completed on 5/17/12 from 1:00 P.M. to 2:10 P.M., with the Maintenance and Housekeeping/Laundry Directors in attendance. The following was observed:</p> <p>The Medical Records office was entered through a door in the main hallway from the main entrance of the building. The door was unlocked, and the Medical Records staff person was not in the room. Two sprinkler heads were observed to be mounted in the center portion of the ceiling of the room.</p> | F0516   | <p>Corrective action: An automatic door closer was added to the medical records door and a keypad entry installed. Additional file cabinets were purchased. Other residents having the potential to be affected: Additional file cabinets have been purchased to store open records. An automatic door closer was added to the medical records door and a keypad entry installed. Systematic changes: Medical records not stored in file cabinets will be stored in air tight containers until closed and filed. An automatic door closer was added to the medical records door and a keypad entry installed. We will close and file no less than 15-20 charts per week until all records have been closed and filed. Additional file cabinets will be purchased to store medical records. The Medical Records designee has</p> | 06/20/2012   |  |   |  |

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| NAME OF PROVIDER OR SUPPLIER<br><br>DANVILLE REGIONAL REHABILITATION |  |   |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>255 MEADOW DR<br>DANVILLE, IN 46122 |  |   |  |
| (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>A row of 11 metal file cabinets lined one wall of the room. Multiple [too numerous to count] Resident files were lined up on top of each cabinet. The files were manila expandable folders containing multiple pages of paperwork, and were marked with a "2012" date. A long, folding utility table was positioned under the window of the room. More files were lined up on the table.</p> <p>A counter top on the opposite side of the room from the file cabinets also had multiple files.</p> <p>The Director of Nursing Services entered the room and indicated the Medical Records staff person had just been in the room, and thought he was in the hallway. She left the room, but was unable to locate the staff person. In an interview at that time, the Director of Nurses indicated the facility had been without someone to manage the medical records for about 6 months. The current staff person assigned started about 3 months ago, and was still working on getting all of the records organized. She indicated his intention was to place a completed file in the metal file cabinets. The files currently out were ones he still needed to work on.</p> <p>3.1-50(d)</p> |   | <p>been re-educated regarding keeping the medical records storage area locked while not in attendance. Monitoring: Identified trends will be reviewed in monthly QA x 3 months then quarterly thereafter to determine if further education or monitoring is needed. Identified non-compliance will result in 1:1 re-education with repeat non-compliance resulting in disciplinary action. Any identified trend will be forward to the Admn for review and presented to QA to determine further educational needs (ongoing). Date of completion: 6-20-12</p> |  |  |   |  |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>155132 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____ | X3) DATE SURVEY COMPLETED<br><br>05/21/2012 |
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|--|--|

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