

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155507	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/07/2012
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NAME OF PROVIDER OR SUPPLIER SYCAMORE SPRINGS REHABILITATION CENTRE	STREET ADDRESS, CITY, STATE, ZIP CODE 215 W HIGH ST LIBERTY, IN 47353
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F0000	<p>The visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: April 30, May 1, 2, 3, and 7, 2012</p> <p>Facility number: 000510 Provider number: 155507 Aim number: 100285440</p> <p>Survey team: Sharon Lasher, RN,TC Angel Tomlinson, RN (May 1, 2, 3, and 7, 2012) Barbara Gray, RN Leslie Parrett, RN</p> <p>Census bed type: SNF/NF: 34 Total: 34</p> <p>Census payor type: Medicare: 7 Medicaid 20 Other: 7 Total: 34</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on May 15, 2012 by Bev Faulkner, RN</p>	F0000	<p>Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. This plan of correction is prepared and submitted because of requirement under state and federal law. Please find enclosed the plan of correction for the survey ending May 7, 2012. Due to the low scope and severity of the survey finding, please find sufficient documentation providing evidence of compliance with the plan of correction. This documentation serves to confirm the facility's allegation of compliance. Thus, the facility respectfully requests the granting of paper compliance. Should additional information be necessary to confirm said compliance, feel free to contact me.</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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F0221 SS=D	<p>483.13(a) 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 observation, interview and record review, the facility failed to ensure that a medical symptom was identified for the use of restraints for 2 of 3 residents reviewed in the sample of 3 who met the criteria for restraints. (Resident #20 and #26)</p> <p>Findings include:</p> <p>1.) The record of Resident #20 was reviewed on 5/1/12 at 4:15 p.m.</p> <p>During an observation on 5/2/12 at 9:47 a.m., Resident #20 was in a wheelchair in the lounge with a self release belt on. Resident #20 was sitting still in the wheelchair without any repetitive movement, rocking or trying to throw herself out of the chair.</p> <p>During an observation on 5/3/12 at 11:44 a.m., Resident #20 was sitting still in her wheelchair in the lounge.</p> <p>During an observation on 5/3/12 at 1:25 p.m., CNA #7 and CNA #8 moved Resident #20 from the lounge (in her wheelchair where she was</p>	F0221	<p>F221 Requires the facility to ensure that a medical symptom is identified for the use of restraints. The facility will ensure this requirement is met through the following:1. Resident #20 and #26 were not harmed. Their restraints were discontinued.2. All residents have the potential to be affected. Currently there are no residents utilizing restraints at this time.3. The physical restraint use and application policy and procedure was reviewed with no changes made. (See attachment A) The staff was inserviced on the above procedure.4. The DON or her designee will utilize the nursing monitoring tool to ensure that if a restraint is ordered per the physician that a medical diagnosis is present for use. The audit will be conducted daily times four weeks, then weekly times four weeks, then every two weeks times two months, then quarterly thereafter until compliance is maintained. (See attachment B) The audits will be reviewed during the facility's quarterly quality assurance meetings and the plan of action will be adjusted accordingly.5. The corrective measures will be completed on</p>	05/14/2012			

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	<p>sitting still) to the bathroom in Resident #20's room. CNA #1 asked Resident #20 to remove her self release belt before taking her to the bathroom and Resident #20 was unable to remove the self release belt.</p> <p>During an observation on 5/7/12 at 10:00 a.m., Resident #20 was up in the lounge in her wheelchair without any movement. She was sitting still in her wheelchair.</p> <p>During random observations, Resident #20 was observed every day of the survey up in her wheelchair in the lounge without any repetitive movement, rocking, or tremors.</p> <p>Resident #20's MDS (Minimum Data Set) assessment, dated 2/3/12, indicated the following:</p> <ul style="list-style-type: none"> - BIMS (Brief Interview for Mental Status) 2, 0-7, severe impairment - transfer, extensive assistance - walk in hall, extensive assistance - trunk restraint, yes <p>Resident #20's care plans, dated 2/10/12, indicated "Problem, the resident requires the use of a wheelchair seatbelt due to safety, constant body movement, extrapyramidal disease (any deviation</p>		or before May 14, 2012.		

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	<p>from or interruption of the normal structure or function of any body part) with involuntary movement and tremors in an effort to maintain the highest practicable physical mental, and psychosocial well-being for the resident. Goal: the resident will be free from potential negative outcomes and or decline in function range of motion. Interventions, observe for potential negative outcomes and or functional decline and intervene as needed, educate the family and or responsible party in regards to the reasons for restraint use and the potential negative outcomes, responsible party to sign restraint consents, head to toe skin assessment weekly to monitor skin integrity for redness and breakdown, visit resident at least once per hour, check, release, reposition at least every two hours while restrained, assist with toileting per schedule and as needed, observe and report changes in mood, behavior, nutritional status, or urinary status, evaluate restraint for efficacy and potential need for reduction, review restraint use upon initiating, 30 days, 60 days, 90 days, then at least quarterly thereafter, refer to therapy as needed and alarmed seat belt in wheelchair, release every 2 hours per physician order."</p>			

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	<p>Resident #20's physician recapitulation order, dated 5/12, indicated "seatbelt alarm on when in wheelchair."</p> <p>Resident #20's "Initial Physical Restraint Assessment," dated 5/20/11, included, "alarmed seat belt when in wheelchair due to abnormal movement and positioning."</p> <p>Resident #20's "Restraint Review" type of review, 30 days, dated 6/20/11, indicated "no change in cognition, ambulation, transfer, bed mobility, social interaction, ROM (range of motion), ADLs (activities of daily living), skin condition or continence. Date of last attempt at permanent removal of restraint, 6/20/11. Explain what occurs when restraint is removed, resident will try to stand and fall. Explain rational for continued use of this device, resident's safety."</p> <p>Resident #20's "Restraint Review" type of review, 60 days, dated 7/20/11, indicated "no change in cognition, ambulation, transfer, bed mobility, social interaction, ROM, ADLs, skin condition or continence. Date of last attempt at permanent removal of resident 7/20/11. Explain</p>			

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	<p>what occurs when restraint is removed, Resident tried to stand without assistance. Explain rational for continued use of this device, resident's safety."</p> <p>Resident #20's "Restraint Review" type of review, 90 days, dated 8/20/11, indicated "no change in cognition, ambulation, transfer, bed mobility, social interaction, ROM, ADLs, skin condition or continence. Date of last attempt at permanent removal of resident, 8/20/11. Explain what occurs when restraint is removed, brought resident in and removed seat belt after 3 minutes tries to stand and fall. Explain rational for continued use of this device, safety."</p> <p>Resident #20's "Restraint Review" type of review, quarterly, dated 12/20/11, indicated "no change in cognition, ambulation, transfer, bed mobility, social interaction, ROM, ADLs, skin condition or continence. Date of last attempt at permanent removal of resident, 12/20/11. Explain what occurs when restraint is removed, tried to stand and fall, leaning in chair. (restraint was removed in this time frame) this occurred within 2 minutes of restraint being removed. Explain rationale for</p>			

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	<p>continued use of this device, safety."</p> <p>During interview with on 5/3/12 at 1:35 p.m., LPN #9 stated "(Resident #20) has tremors and shakes and that is why she is restrained."</p> <p>During interview with ADON (Assistant Director of Nursing) on 5/7/12 at 2:48 p.m., indicated Resident #20's last fall was on 5/20/11 and was from her bed. She also indicated the only documentation of Resident #20 having tremors was on the care plan and no other documentation of any other movement was documented in Resident #20's clinical record.</p> <p>2.) Review of Resident #26's record on 5/3/12 at 1:30 p.m., indicated the resident's diagnoses included, but were not limited to, Alzheimer's disease, history of emboli/stroke, history of cerebral vascular accident, severe dementia, congestive heart failure, osteoporosis and acute renal disease.</p> <p>On 5/3/12 at 12:45 p.m., Resident # 26 was observed in the dining room sitting upright with no leaning observed in her wheelchair, an alarmed Velcro seat belt was attached across her abdominal area.</p>			

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	<p>During observation of Resident # 26 on 5/3/12 at 1:40 p.m., the resident was sitting upright in her wheelchair in the lounge area with an alarmed Velcro seatbelt attached in front. No leaning was observed. The seat belt was attached to the wheelchair from where the seat was bolted to the frame at the back of the chair, then under the arm rests and across the resident's abdominal with the Velcro closure in the front.</p> <p>Interview with the resident at this time indicated she could not understand how to release the alarmed Velcro seatbelt.</p> <p>On 5/3/12 at 2:00 p.m., interview with DON (Director of Nursing) indicated "On 8/1/10 was the original date when Resident # 26 was placed in a Velcro self-release alarmed seatbelt due to unsteady gait and falls." She indicated "At that time when she would release it, it would alarm and was effective with preventing falls." The DON indicated "On 9/30/10, the resident could no longer release the self-release alarmed seatbelt and it became a restraint."</p> <p>Physician orders, dated 9/30/11, indicated "alarmed seatbelt while up in wheel chair due to history of</p>			

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	<p>cerebral vascular accident related to poor trunk control. FYI: start restraint release."</p> <p>Interview with ADON(Assistant Director of Nursing) on 5/3/12 at 2:50 p.m., indicated she completes the Restraint Reviews for Resident # 26. She indicated she recently completed a 30 day review on Resident # 26's restraint and the resident tried to stand up so the restraint was reapplied due to the resident's safety.</p> <p>"Initial Physical Restraint Assessment," dated 8/1/10, indicated "diagnosis/condition or symptoms that lead to restraint use: Dementia/tremors and poor trunk control." Alternatives attempted prior to restraint application and state outcomes. 12/09 pressure pad, resident removed it. 3/10/10 clip alarm, resident removed, lowered alarm but still removed. 3/10 pommel cushion, slid, did not help with support can still get up out of it. 4/10 drop seat, no change. MD reviewed medications 8/1/10, 10/12/11, with no changes. (no date)contoured mattress, still gets up out of it."</p>						

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	<p>Quarterly Reassessment for physical restraints was completed by the ADON (Assistant Director of Nursing) on 4/18/12 with no change recommended and no attempt at removal. On 5/1/12, a 30 day Restraint Review indicated "date of last attempt at removal of restraint 5/1/12. Explain what occurs when restraint is removed: Resident try's [sic] to get up out of wheel chair on her own. Explain rational [sic] for continued use of this device: Resident safety"</p> <p>Review of revised care plan, dated 3/15/12, indicated Problem: "The resident requires the use of: alarmed seat belt due to:history of falling, Alzheimer's, poor safety awareness." "Goal: the resident will be free from potential negative outcomes and or decline in functioning associated with restraint use such as increased incidents of incontinence, declines in range of motion, decreased ability to ambulate, loss of muscle tone, the development of skin problems, increased agitation, reduced social interaction, aspiration, etc. Thru next review.</p> <p>Interventions: Observe for potential negative outcomes and or functional</p>			

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	<p>decline and intervene as needed. Educate the responsible party in regards to the reason for restraint use and the potential for negative outcomes. Head to toe skin assessment to be completed weekly by a licensed nurse. Observe for changes in mood, behavior, nutritional status, or urinary status. Evaluate restraint for efficacy and potential need for reduction PRN. Review restraint use prior to initiating, 30 days, 60 days, and 90 days, then at least quarterly thereafter. Refer to therapy as needed. Assist resident to activities of interest. Responsible party to sign consent. Resident to be checked hourly, and check, release, reposition at least every two hours. Assist with toileting per schedule and as needed."</p> <p>On 5/7/12 at 2:20 p.m., review of a document provided by the Administrator titled "Manufacturer's Guidelines for Product use and specification sheet"... "Description: Hook and loop seatbelt with alarm... Not recommended for Patients who need a restraint. Patients who are not able to self release the belt..." "Operation: Alarm box features on/off</p>				

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	<p>switch. With alarm switched on, at the moment the belt is separated, the alarm sounds to alert patient and staff of the immediate fall risk. Once belt is refastened, the alarm will automatically reset."</p> <p>"Physical Restraint Use And Application Policy: It is the policy of this facility to prohibit the use of restraints for the purpose of discipline or convenience. Restraint use will be limited only to circumstances in which the resident has medical symptoms that warrant the use to assist in reaching and/or maintaining their highest level of functioning..."</p> <p>"3. A physician's telephone order will be obtained and will include type, duration, frequency and medical condition or symptoms that warrant use..."</p> <p>"7. A restraint release record will be initiated to document that the resident is checked every hour and released or repositioned every 2 hours."</p> <p>"10. Health Care Plan team will review and evaluate the use of the restraint every 30 days for the first 90 days, then quarterly or with a change in condition. The Health Care Plan team will attempt reductions and/or removal at least quarterly and document results on restraint</p>						

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	assessment..." 3.1-3(w)			

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F0246 SS=D	<p>483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.</p> <p>Based on observation, interview and record review, the facility failed to ensure proper positioning during dining to promote good nutrition for a resident with significant weight loss for 1 of 4 residents reviewed that met the criteria for nutrition (Resident #27).</p> <p>Finding include:</p> <p>1.) Review of Resident #27's record on 5-1-12 at 3:30 p.m., indicated the resident's diagnoses included, but were not limited to, hypertension, Coronary Artery Disease (CAD), Chronic Renal Disease (CRD), Open area, osteoporosis, arthritis, Cerebral Vascular Accident (CVA), Chronic Obstructive Pulmonary Disease (COPD), anemia, Chronic Kidney Disease (CKD), dementia, right pelvic fracture, depression and renal failure.</p> <p>The initial care plan for Resident #27,</p>	F0246	F246 Requires the facility to ensure proper positioning during dining to promote good nutrition for a resident with significant weight loss. The facility will ensure this requirement is met through the following:1. Resident #27 was not harmed. Resident was placed on restorative dining.2. All residents have the potential to be affected. All residents were observed in the dining room and assessed to ensure that they were properly positioned at the table and to ensure that they could reach their meal. If a resident is having positioning problems during meal services, occupational therapy will screen for positioning.3. An inservice was conducted on proper positioning for resident during meal service. 4. The DON or her designee will monitor at least one meal service a day to ensure that all residents are properly positioned at the table and that they can reach their meal daily times four weeks, then weekly times four weeks, then every two weeks times two months, then quarterly thereafter until compliance is	05/14/2012

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	<p>dated 1-21-12, indicated the resident required one person assist with ADL's. The interventions included, but were not limited to, encourage to eat at meals, provide assistance with meals.</p> <p>The Minimum Data Set (MDS) assessment, dated 3-14-12, for Resident #27 indicated the resident required supervision of one person to physically assist with eating.</p> <p>During observation on 5-2-12 at 12:30 p.m., Resident # 27 was eating lunch. The resident was attempting to reach for a drink and was spilling it. The resident's wheelchair was not locked and the resident was scooting backwards in her wheelchair away from the table. The resident wheelchair sat low compared to the height of the table and was far from the table. When queried if she could reach the table, the resident smiled and did not answer. CNA #2 moved the resident back up to the table and did not lock the wheelchair in place. The observation indicated no assistance was provided by staff to Resident #27 with her meal.</p> <p>During observation on 5-2-12 at 12:55 p.m., Resident #27 was sitting in the dining room and was positioned far</p>		<p>maintained. (See attachment B) The audits will be reviewed during the facility's quarterly assurance meetings and the plan of action will be adjustly accordingly.5. The above corrective measures will be completed on or before May 14, 2012.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155507	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/07/2012
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NAME OF PROVIDER OR SUPPLIER SYCAMORE SPRINGS REHABILITATION CENTRE	STREET ADDRESS, CITY, STATE, ZIP CODE 215 W HIGH ST LIBERTY, IN 47353
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	<p>away from the table. The observation indicated no assistance was provided by staff to Resident #27 with her meal.</p> <p>During observation on 5-2-12 at 1:10 p.m., CNA #2 brought Resident #27 from the dining room to dayroom.</p> <p>Interview with the Director Of Nursing (DON) on 5-7-12 at 1:21 p.m. indicated the nurse was responsible to ensure residents were positioned properly at meal times.</p> <p>3.1-3(v)(1)</p>			

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F0279 SS=D	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on observation, interview and record review, the facility failed to have a plan of care to prevent dehydration for a resident with a history of dehydration and at risk for dehydration for 1 of 21 residents reviewed for care planning (Resident #27).</p> <p>Finding include:</p> <p>1.) Review of Resident #27's record on 5-1-12 at 3:30 p.m., indicated the</p>	F0279	F279 Requires the facility to have a plan of care to prevent dehydration for a resident with a history of dehydration and risk of dehydration. The facility will ensure this requirement is met through the following:1. Resident #27 was not harmed. A risk for dehydration care plan was placed in the resident's plan of care.2. All residents have the potential to be affected. All residents records were reviewed and a care plan was placed in their plan of care if they were determined to be a dehydration risk.3. The care plan development and review policy and procedure was	05/14/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155507	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/07/2012
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	<p>resident's diagnoses included, but were not limited to, hypertension, Coronary Artery Disease (CAD), Chronic Renal Disease (CRD), osteoporosis, arthritis, Cerebral Vascular Accident (CVA), Chronic Obstructive Pulmonary Disease (COPD), anemia, Chronic Kidney Disease (CKD), Congestive Heart Failure (CHF), dementia, anxiety, right pelvic fracture, depression and renal failure.</p> <p>The record of Resident #27 indicated she was admitted to the facility on 1-21-12 from the local hospital with an diagnoses of dehydration, chronic renal impairment, altered mental status, anemia and chronic illness.</p> <p>The record of Resident #27 indicated she was sent to the hospital on 2-15-12 and 3-4-12.</p> <p>The Minimum Data Set (MDS) assessment for Resident #27, dated, 3-14-12, indicated the resident required supervision of one person to physically assist with eating.</p> <p>The nutritional assessment for Resident #27, dated, 3-16-12, indicated the resident's estimated fluid needs were 1710 milliliters per day.</p>		<p>reviewed with no changes made. (See attachment C) The staff was inserviced on the above procedure.4. All residents will have their physician orders and history and physical reviewed to ensure if they are a risk for dehydration that it is care planned. The DON or her designee will utilize the nursing monitoring tool to ensure that residents who are at risk for dehydration is care planned daily times for weeks, then weekly times four weeks, then every two weeks times two months, then quarterly thereafter until compliance is maintained.(See attachment B) The audits will be reviewed during the facility's quarterly quality assurance meetings and the plan of action will be adjusted accordingly. 5. The above corrective measures will completed on or before May 14, 2012.</p>	

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	<p>During interview with the Assistant Director Of Nursing (ADON) on 5-2-12 at 2:05 p.m., indicated there was not a plan of care in place for Resident #27 to prevent dehydration.</p> <p>During interview with the MDS Coordinator on 5-2-12 at 2:20 p.m., indicated Resident #27 had a lot of recent changes. The MDS coordinator indicated Resident #27 was at risk for dehydration and the facility would be putting the resident on a restorative dining program for 6 days a week for one meal a day. The MDS Coordinator indicated the Speech Therapist would be putting a plan of care in place for an eating and drinking program for Resident #27.</p> <p>During interview with the Dietician on 5-2-12 at 2:26 p.m., the Dietician indicated she had assessed Resident #27's fluid intake needs to be 1710 milliliters a day. The Dietician indicated nursing would be responsible to put a plan of care in place for dehydration.</p> <p>3.1-35(a)</p>			

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F0309 SS=D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on observation, interview and record review, the facility failed to implement an intervention of geri sleeves to prevent skin tears for a resident that had acquired skin tears for 1 of 1 residents that met the criteria for skin issues (Resident#27).</p> <p>Finding include:</p> <p>1.) Review of Resident #27's record on 5-1-12 at 3:30 p.m., indicated the resident's diagnoses included, but were not limited to, hypertension, Coronary Artery Disease (CAD), Chronic Renal Disease (CRD), Open area, osteoporosis, arthritis, Cerebral Vascular Accident (CVA), Chronic Obstructive Pulmonary Disease (COPD), anemia, Chronic Kidney Disease (CKD), dementia, right pelvic fracture, depression and renal failure.</p> <p>The admission assessment for</p>	F0309	F309 Requires the facility to implement an intervention of geri sleeves to prevent skin tears for a resident that had acquired skin tears. The facility will ensure this requirement is met through the following:1. Resident #27 was not harmed. Resident #27 refuses to wear geri-sleeves or elbow protectors. Skin repair cream will be applied to resident twice a day for six weeks and then everyday.2. All residents have the potential to be affected. Residents weekly skin sheets were reviewed and any resident that had skin tears an intervention was put into place to help prevent further skin issues.3. The skin care management program policy and procedure was reviewed with no changes made. (See attachment D) The staff was inserviced on the above procedure.4. The DON or her designee will review daily all skin sheets and incident reports and if a resident is noted to have a skin tear an intervention will be placed to help prevent further skin issues. The nursing monitoring tool will utilized daily times four	05/14/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155507	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/07/2012
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	<p>Resident #27, dated 1-21-12, indicated the resident was admitted with two skin tears.</p> <p>The care plan for Resident #27, dated 1-28-12, indicated the resident was at risk for skin tears and bruising due to the normal aging process of the skin with decrease subcutaneous layer. The interventions were as follows: head to toe assessment weekly, notify physician and responsible party as needed, apply lotion as needed, monitor labs as ordered, inform resident to guard arms while going through the doorway, geri sleeves to arms, steri strips to arms with bacitracin and dressing. The interventions, dated 3-4-12, were steri strips, bacitracin and kerlix, maintain to check toilet riser for sharp edges. The interventions added on 3-30-12 were 1 on 1 inservice with CNA on transferring the resident to wheelchair and toileting schedule.</p> <p>The skin condition documentation for Resident #27, dated 3-4-12, indicated she acquired a skin tear measuring 1.0 centimeters (cm) by 0.1 cm on her right elbow.</p> <p>The skin condition documentation for Resident #27, dated 3-7-12, indicated the resident acquired three skin tears,</p>		<p>weeks, weekly times four weeks, then every two weeks times two months, then quarterly thereafter until compliance is maintained. (See attachment B) The audits will be reviewed during the facility's quarterly assurance meetings and the plan of action will be adjusted accordingly.5. The above corrective measure will be completed on or before May 14, 2012.</p>		

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NAME OF PROVIDER OR SUPPLIER SYCAMORE SPRINGS REHABILITATION CENTRE				STREET ADDRESS, CITY, STATE, ZIP CODE 215 W HIGH ST LIBERTY, IN 47353			
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	<p>measuring 2 cm, 1 cm and 10 cm. The documentation did not indicate the locations of the skin tears.</p> <p>The skin condition documentation for Resident #27, dated, 3-30-12, indicated the resident acquired a skin tear to her right wrist measuring 0.1 cm by 0.1 cm.</p> <p>The physician order for Resident #27, dated 3-7-12, indicated the resident was ordered geri sleeves to bilateral upper extremities.</p> <p>The physician order for Resident #27, dated 4-24-12, indicated the resident was ordered geri sleeves to bilateral upper extremities.</p> <p>The physician recapitulation (recap), dated May 2012, indicated the resident was to have geri sleeves to bilateral upper extremities.</p> <p>During observation on 5-2-12 at 9:00 a.m., Resident #27 was sitting in her wheelchair in an activity. The resident did not have geri sleeves on her arms. The resident's wheelchair arms did not have sheep skin on them. The resident was not observed with skin tears on her arms.</p> <p>During interview with CNA #2 and</p>						

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	<p>CNA #3 on 5-2-12 at 1:25 p.m., indicated the CNA'S were responsible to apply geri sleeves for residents. CNA #2 and CNA #3 indicated that their CNA assignment was not marked for Resident #27 to wear geri sleeves. CNA #2 and CNA #3 indicated Resident #27 had never wore geri sleeves that they were aware of. CNA #2 indicated she would check with the Assistant Director Of Nursing (ADON) and find out if the resident was supposed to wear geri sleeves.</p> <p>Interview with the ADON on 5-2-12 at 1:55 p.m., indicated she discontinued the geri sleeves for Resident #27. The ADON indicated she could discontinue the geri sleeves without an physician order. The ADON indicated the geri sleeves should have never been a doctors order, it was done as a nursing measure.</p> <p>During observation on 5-7-12 at 10:25 a.m., Resident #27 was sitting in her wheelchair, the resident had a skin tear on her right forearm with two steri strips in place and a skin tear on her upper right arm with three steri strips in place. The resident's wheelchair had sheepskin on the arms.</p> <p>3.1-37(a)</p>						

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F0315 SS=D	<p>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER</p> <p>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>Based on observation, interview and record review, the facility failed to assist a dependent resident to the bathroom and provide a toileting program for 1 of 2 residents who met the criteria for toileting decline (Resident #27).</p> <p>Finding include:</p> <p>1.) Review of Resident #27's record on 5-1-12 at 3:30 p.m., indicated the resident's diagnoses included, but were not limited to, hypertension, Coronary Artery Disease (CAD), Chronic Renal Disease (CRD), osteoporosis, arthritis, Cerebral Vascular Accident (CVA), Chronic Obstructive Pulmonary Disease (COPD), anemia, Chronic Kidney</p>	F0315	F315 Requires the facility to assist a dependent resident to the bathroom and provide toileting programs for residents who meet criteria for toileting decline. The facility will ensure this requirement is met through the following :1. Resident #27 was not harmed. Resident #27 toileting program was reviewed and deemed appropriate.2. All residents have the potential to be affected. All toileting programs were reviewed and deemed appropriate for the residents.3. The toileting program procedure was reviewed with no changes. (See attachment E) The staff was inserviced on the above procedure.4. The DON or her designee will monitor three residents a day to ensure that the staff is assisting residents accordingly to their toileting schedule by utilizing the nursing audit tool daily times four weeks, then weekly times four weeks, then every two weeks times two	05/14/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155507	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/07/2012
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	<p>Disease (CKD), Congestive Heart Failure (CHF), dementia, anxiety, right pelvic fracture, depression and renal failure.</p> <p>The urinary and bowel continence evaluation for Resident #27, dated 1-21-12 indicated the resident had no history of incontinence. The resident was admitted to the facility continent of urine and bowel.</p> <p>The Minimum Data Set (MDS) assessment for Resident #27, dated 1-24-12 indicated the resident was continent of bowel and bladder. The resident required limited assistance of one person to go the restroom.</p> <p>The local hospital note for Resident #27, dated 3-4-12, indicated the resident had a fall at the facility and acquired a pubic rami (pelvic) fracture.</p> <p>The MDS assessment for Resident #27, dated 3-14-12, indicated the resident was occasionally incontinent of bowel and frequently incontinent of bladder. The resident required extensive assistance of two people to go to the bathroom.</p> <p>The initial care plan for Resident #27, dated 1-21-12, indicated the resident</p>		<p>months, then quarterly thereafter until compliance is maintained. (See attachment B) The audits will be reviewed during the facility's quarterly quality assurance meetings and the plan of action will be adjusted accordingly.5. The above corrective measures will be completed on or before May 14, 2012.</p>		

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	<p>required assistance of one person with Activities Of Daily Living (ADL). The interventions included, but were not limited to, assist the resident to the bathroom before and after meals, after rising and before going to bed.</p> <p>The care plan for Resident #27, dated 3-28-12, indicated the resident had multiple risk for falls which included, but were not limited to fracture of the pelvis. The interventions included, but were not limited to, toileting schedule.</p> <p>The care plan for Resident #27, dated 3-28-12, indicated the resident was incontinent of bladder due to pain, dementia and needs assistance to the toilet. The interventions included, toileting schedule of before and after meals and as needed and provide peri care each shift and with each incontinence episode.</p> <p>During observation on 5-2-12 at 9:00 a.m., Resident #27 was in an activity.</p> <p>During observation on 5-2-12 at 9:52 a.m., Resident #27 was sitting in the dayroom.</p> <p>During observation on 5-2-12 at 10:54 a.m., Resident #27 was in therapy.</p> <p>During observation on 5-2-12 at 11:45</p>			

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	<p>a.m., Resident #27 was receiving a respiratory treatment with the Respiratory Therapist present.</p> <p>During observation on 5-2-12 at 12:02 p.m., the Respiratory Therapist took Resident #27 to the dining room.</p> <p>During observation on 5-2-12 at 12:30 p.m., Resident #27 was sitting in the dining room.</p> <p>During observation on 5-2-12 at 1:10 p.m., CNA #2 brought Resident #27 from the dining room to the dayroom.</p> <p>During interview with CNA #2 on 5-2-12 at 1:20 p.m., the CNA indicated she was caring for Resident #27. CNA #2 indicated she did not know Resident #27 was on a scheduled toileting program. CNA #2 provided her CNA assignment sheet and it indicated under toileting for Resident #27 a "D." CNA #2 indicated this meant the resident was dependent on staff for toileting needs. CNA #2 indicated she would take Resident #27 to the restroom now. Resident #27 indicated it "would be wonderful to go to the bathroom."</p> <p>During observation on 5-2-12 at 1:25 p.m., CNA #2 and CNA #3 assisted Resident #27 to the restroom. This</p>			

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NAME OF PROVIDER OR SUPPLIER SYCAMORE SPRINGS REHABILITATION CENTRE	STREET ADDRESS, CITY, STATE, ZIP CODE 215 W HIGH ST LIBERTY, IN 47353
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	<p>indicated the resident was observed not receiving assistance to the bathroom for 4 hours and 25 minutes. The resident's brief was soaked with dark, foul smelling urine. The back of the resident's pants were wet with urine. The resident urinated and had a bowel movement while on the toilet. The resident indicated she felt better since going to the bathroom.</p> <p>3.1-41(a)(2)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155507	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/07/2012
NAME OF PROVIDER OR SUPPLIER SYCAMORE SPRINGS REHABILITATION CENTRE			STREET ADDRESS, CITY, STATE, ZIP CODE 215 W HIGH ST LIBERTY, IN 47353		
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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.</p> <p>Based on observation, interview and record review, the facility failed to implement interventions to prevent bruising for a resident with multiple bruises and failed to transfer a resident in a safe method for 2 of 10 residents that met the criteria for accidents (Resident #37 and #5).</p> <p>Findings include:</p>	F0323	<p>F323 Requires the facility to implement interventions to prevent bruising for a resident with multiple bruises and will transfer a resident in a safe method. The facility will ensure this requirement is met through the following:1. Resident #37 and #5 were not harmed. Resident #37 lap tray was padded and her husband was inserviced on safe transfers. A care plan was placed regarding the bruises in the resident' plan of care.2. All residents have the potential to be affected. Residents that have acquired bruises over the last three months had their incident reports reviewed and an intervention to was put in place to help prevent further bruising as well as a care plan put into place regarding the bruise. Also, all residents that require assist with transfers will have a gait belt utilized for transfers.3 The skin care management policy and procedure as well as the transferring a resident from the bed to a chair policy and procedure and care plan development policy and procedure was reviewed with no changes.(See attachment D, F</p>	05/14/2012	

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NAME OF PROVIDER OR SUPPLIER SYCAMORE SPRINGS REHABILITATION CENTRE			STREET ADDRESS, CITY, STATE, ZIP CODE 215 W HIGH ST LIBERTY, IN 47353		
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	<p>1.) The record or Resident #37 was reviewed on 5/2/12 at 10:00 a.m. Resident #37's diagnoses included but were not limited to, Huntington's disease (central nervous system movement disorder) and anxiety.</p> <p>Resident #37's MDS (Minimum Data Set), assessment, dated 3/19/12, indicated Resident #37's cognitive skills were severely impaired and she</p>		<p>and C) The staff was inserviced on the above procedures.4. The DON or her designee will review skin reports as well as incident reports to ensure that if a bruise is present an intervention is put into place to help prevent further bruising. If a bruise is noted a care plan will be place in the resident's plan of care. The DON or her designee will also watch three transfers a day to ensure the staff is utilizing a gait belt. The DON or her designee will utilize the nursing monitoring tool (See attachment B) to document their findings daily times four weeks, weekly times four weeks, then every two weeks times two months, then quarterly thereafter until compliance is maintained. The audits will be reviewed during the facility's quarterly quality assurance meetings and plan of action will be adjusted accordingly.5. The above corrective measures will be completed on or before May 14, 2012.</p>		

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NAME OF PROVIDER OR SUPPLIER SYCAMORE SPRINGS REHABILITATION CENTRE				STREET ADDRESS, CITY, STATE, ZIP CODE 215 W HIGH ST LIBERTY, IN 47353			
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	<p>had a trunk restraint.</p> <p>Resident #37's care plan, dated 5/25/11 and updated 3/20/12, indicated "Problem the resident has multiple health conditions, Huntington's disease and is at risk for complications associated with these conditions, abnormal body movement. Goal, the resident will be free from complications associated with listed conditions thru next review. Interventions, assess vital signs as needed, monitor for complications and report any findings to charge nurse for further evaluation and possible physician and responsible party notification, administer medications as ordered, built in pommel cushion for positioning and resident's pommel cushion is for positioning due to hip thrusting due to Huntington's disease. Resident is unable to rise on her own."</p> <p>During an observation on 5/2/12 at 10:30 a.m., Resident #37 was observed up in the lounge, in a Broda chair with a tray on the Broda chair. Resident #37 was thrusting her arms and hips and hitting the tray with her legs.</p> <p>During an observation 5/3/12 at 1:13 p.m., Resident #37 was observed up</p>						

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NAME OF PROVIDER OR SUPPLIER SYCAMORE SPRINGS REHABILITATION CENTRE	STREET ADDRESS, CITY, STATE, ZIP CODE 215 W HIGH ST LIBERTY, IN 47353
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	<p>in the lounge, in a Broda chair with a tray on the Broda chair. She was thrusting her hips and hitting the tray with her legs. CNA #7 and CNA #3 removed Resident #37 from the lounge in her Broda chair with a tray on it at this time and took her to her room to perform incontinence care. Resident #37's legs were both observed. Resident #37's left upper leg had one bruise and her lower leg had one bruise no bruising was observed on her right leg.</p> <p>During an observation on 5/7/12 at 1:45 p.m., the Wound Nurse was observed measuring the bruises on Resident #37's legs:</p> <ul style="list-style-type: none"> - right upper leg, 2.5 cm (centimeters) x 3 cm - right upper leg, 1.7 cm x 1.8 cm - left upper leg, 2 cm x 2 cm - left upper leg, 2 cm x 4.4 cm - left upper leg, 2.5 cm x 2.8 cm - left lower leg, 5.5 cm x 1.5 cm - left lower leg, 2 cm x 2 cm <p>Resident #37's "Skin Condition Flowsheet for Non-Pressure related Skin Conditions" provided by the wound nurse on 5/7/12 at 4:00 p.m., indicated the following bruises:</p> <ul style="list-style-type: none"> - 4//20/12, right upper thigh, 2.5 cm x 3 cm, under comments/description "out with husband" 4/19 			

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	<ul style="list-style-type: none"> - 4/28/12, bruises, no change - 5/4/12, bruises, no change - 4/20/12, right upper thigh, 1.7 cm x 1.8 cm, under comments/description, "out with husband" 4/19 - 4/28, bruises, no change - 5/4, no change - 4/20/12, left upper thigh, 2 cm x 2 cm, under comments/description "out 4/19" - 4/27, no change - 5/5, no change - 4/20/12, left upper thigh, 2 cm x 4.4 cm, under additional comments/description, "out 4/19" - 4/27, no change - 5/4, no change - 4/20/12, left upper thigh, 2.5 cm x 2.8 cm, under additional comments/description "out 4/19" - 4/27, no change - 5/4, no change - 4/28/12, left lower leg, 5.5 cm x 1.5 cm, under additional comments/description "went out with husband in car 4/26" - 5/5, 5 cm x 1 cm - 4/2812, left lower leg, 2 cm x 2 cm, under additional 			

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NAME OF PROVIDER OR SUPPLIER SYCAMORE SPRINGS REHABILITATION CENTRE	STREET ADDRESS, CITY, STATE, ZIP CODE 215 W HIGH ST LIBERTY, IN 47353
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	<p>comments/description "went out with husband in car 4/26" - 5/5, 2 cm x 2 cm</p> <p>During an interview on 5/7/12 at 2:21 p.m., the DON (Director of Nursing) indicated the protocol for reporting bruising is the CNAs reports bruising to the nurse and the nurses do an incident report with an investigation on how the bruise occurred. The nurse notifies the physician and family and puts interventions in place to help prevent bruises. The nurse measures the areas and documents them on a skin sheets. The bruises are checked weekly until they are resolved and the bruises are care planned.</p> <p>Resident #20's clinical record lacked a care plan of Resident #20's bruising that occurred in April, 2012.</p> <p>During an interview with the Wound Nurse on 5/7/12 at 2:40 p.m., she indicated she thinks Resident #37 got the bruises when she was out with her husband because when she does her skin assessment and finds a bruise she looks to see if there has been a fall or a reason for the bruise and this had not happened but she had been out with her husband a day or so before she found the bruising.</p>			

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NAME OF PROVIDER OR SUPPLIER SYCAMORE SPRINGS REHABILITATION CENTRE				STREET ADDRESS, CITY, STATE, ZIP CODE 215 W HIGH ST LIBERTY, IN 47353			
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	<p>During an interview with the Wound Nurse on 5/7/12 at 3:34 p.m., indicated abuse was not suspected by the husband because he is so sweet but she thought maybe the resident's legs where bumped when she was out with him. The Wound Nurse also indicated there was no documentation on any education for the husband, investigation or any incident reports completed.</p> <p>During an interview on 5/7/12 at 3:40 p.m., the Corporate Nurse indicated they would get padding or sheep skin and put on Resident #37's plastic tray.</p> <p>2.) Resident #5's record was reviewed on 5/3/12 at 10:48 A.M. Diagnoses included but were not limited to Alzheimer's disease, dementia, gout, and anxiety.</p> <p>Resident #5's quarterly Minimum Data Set assessment, dated 3/20/12, indicated Resident #5 had fallen since his prior assessment, he required extensive assistance of 1 persons for transfer, bed mobility, toileting, walking in the corridor, and walking in his bedroom did not occur.</p> <p>A Fall Risk Assessment for Resident #5, dated 2/23/12, indicated Resident</p>						

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NAME OF PROVIDER OR SUPPLIER SYCAMORE SPRINGS REHABILITATION CENTRE	STREET ADDRESS, CITY, STATE, ZIP CODE 215 W HIGH ST LIBERTY, IN 47353
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	<p>#5 had confusion, an unsteady gait, poor vision, used assistive devices, and had a history of falls.</p> <p>A Fall Care Plan for Resident #5, initiated 8/23/11, indicated the following: Problem-Resident #5 had multiple risk factors for falls, such as Alzheimer's, dementia, and overactive bladder. Goal-Resident #5's risk factors would be reduced in an attempt to avoid injury related to falls through his next review.</p> <p>Interventions-Provide Resident #5 with adequate lighting. Ensure his pathways were clutter free. He would utilize foot wear with non-skid soles. He would be monitored frequently when a call light was unavailable. A fall risk assessment would be completed upon admission, quarterly, and with a significant change. His vital signs would be monitored as indicated. He would receive neurological checks as indicated. The responsible party and MD would be notified if a fall occurred.</p> <p>Interventions added 3/5/12-Resident #5 thought he had fallen in the bathroom. He was sent to the Emergency Room for evaluation and returned with no injures. Remind him to use the call light for assistance.</p> <p>On 5/3/12 at 8:55 A.M., Resident #5</p>			

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NAME OF PROVIDER OR SUPPLIER SYCAMORE SPRINGS REHABILITATION CENTRE				STREET ADDRESS, CITY, STATE, ZIP CODE 215 W HIGH ST LIBERTY, IN 47353			
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	<p>was observed being transferred from his wheelchair to his recliner with the assistance of CNA #7 and CNA #8. Resident #5's cloth catheter bag was placed on the floor in front of his feet. Resident #5 was assisted to stand with CNA #7 and CNA #8 holding him under his arms. Resident #5's leg were shaking rapidly and he stepped on the cloth catheter bag as he pivoted. Resident #5 sat down in the recliner and his legs were elevated. During an interview at that time, CNA #7 indicated it slipped her mind to use the gait belt for transfer and CNA #8 indicated she had forgot to use a gait belt. CNA #7 and CNA #8 were observed wearing gait belts around their waists.</p> <p>The most recent Transferring a Resident procedure provided by the Assistant Director of Nursing on 5/3/12 at 4:25 P.M., indicated the following: Procedure-8.) "Apply gait belt to waist if resident requires weight bearing assist"....</p> <p>3.1-45(a)(1) 3.1-45(a)(2)</p>						

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F0327 SS=D	<p>483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION</p> <p>The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health.</p> <p>Based on observation, interview and record review, the facility failed to provide adequate fluid intake and institute interventions to assist with hydration for 1 of 1 residents that met the criteria for hydration (Resident #27).</p> <p>Finding include:</p> <p>1.) Review of Resident #27's record on 5-1-12 at 3:30 p.m. indicated the resident's diagnoses included, but were not limited to, hypertension, Coronary Artery Disease (CAD), Chronic Renal Disease (CRD), osteoporosis, arthritis, Cerebral Vascular Accident (CVA), Chronic Obstructive Pulmonary Disease (COPD), anemia, Chronic Kidney Disease (CKD), Congestive Heart Failure (CHF), dementia, anxiety, right pelvic fracture, depression and renal failure.</p> <p>The record of Resident #27 indicated she was admitted to the facility on 1-21-12 from the local hospital with</p>	F0327	F327 Requires the facility to provide adequate fluid intake and institute interventions to assist with hydration. The facility will ensure this requirement is met through the following:1. Resident #27 was not harmed. The resident was continued on intake and output and extra fluids are being offered every shift to the resident. The resident was placed on restorative dining and a lab was drawn which was not indicating dehydration.2. All residents have the potential to be affected. The resident's food and fluid acceptance records were reviewed as well as the residents clinical records to determine if they were a dehydration risk. If they were a dehydration risk they will be given extra fluids each shift through medication pass. A hydration cart will be passed everyday at 10am, 2pm and at night to help further promote an increase in fluid intake.3. The hydration management policy and procedure was reviewed with no changes made. (See attachment G) The staff was inserviced on te above procedure.4. The DON or her designee will review the food and fluid acceptance record of residents who are at risk for dehydration to ensure they are	05/14/2012	

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NAME OF PROVIDER OR SUPPLIER SYCAMORE SPRINGS REHABILITATION CENTRE				STREET ADDRESS, CITY, STATE, ZIP CODE 215 W HIGH ST LIBERTY, IN 47353			
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	<p>an diagnoses of dehydration, chronic renal impairment, altered metal status, anemia and chronic illness.</p> <p>Review of Resident #27's record on 5-1-12 at 3:30 p.m. the documentation indicated no dehydration risk assessment was completed.</p> <p>The Minimum Data Set (MDS) assessment for Resident #27, dated 3-14-12, indicated the resident required supervision of one person to physically assist with eating.</p> <p>The nutritional assessment for Resident #27, dated 3-16-12, indicated the resident's estimated fluid needs were 1710 milliliters (ml) per day.</p> <p>The intake of fluid consumption for Resident #27 indicated the following: on 3-7-12 indicated the resident had 780 ml in a 24 hour period, on 3-8-12 the resident had 660 ml of fluid in a 24 hour period, on 3-9-12 the resident had 960 ml in a 24 hour period, on 3-10-12 the resident had 780 ml in a 24 hour period, on 3-11-12 the resident had 900 ml in a 24 hour period, on 3-13-12 the resident had 1020 ml in a 24 hour period, on 3-14-12 the resident had 1080 ml in a</p>		<p>receiving their daily fluid requirements. If a resident does not consume their daily fluid requirements then the physician will be contacted for further interventions. The DON or her designee will complete the nursing audit tool daily times four weeks, weekly times four weeks, then every two weeks times two months, then quarterly thereafter until compliance is maintained. (See attachment B)5. The above corrective measures will be completed on or before May 14, 2012.</p>				

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	<p>24 hour period and on 3-15-12 the resident had a 600 ml in a 24 hour period. The documentation indicated no further intake of fluids for March 2012.</p> <p>The intake of fluid consumption for Resident #27 indicated the following: on 4-24-12 the resident had 360 ml in a 24 hour period, on 4-25-12 the resident had 780 ml in a 24 hour period, on 4-26-12 the resident had 960 ml in a 24 hour period, on 4-27-12 the resident had 960 ml in a 24 hour period, on 4-28-12 the resident had 900 ml in a 24 hour period, on 4-29-12 the resident had 780 ml in a 24 hour period and 4-30-12 the resident had 800 ml in a 24 hour period.</p> <p>The intake of fluid consumption for Resident #27, dated 5-1-12, indicated the resident had 460 ml of fluid in a 24 hour period.</p> <p>During observation on 5-2-12 at 12:30 p.m., Resident #27 was eating lunch. The resident was attempting to reach for her fruit punch and was spilling it. The resident's wheelchair was not locked and the resident was scooting backwards in her wheelchair away from the table. The resident was sitting low in her wheelchair and was</p>			

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	<p>far from the table. When queried if she could reach her food, the resident smiled and did not answer. CNA # 3 moved the resident back up to the table and did not lock the wheelchair in place.</p> <p>During observation on 5-2-12 at 12:55 p.m., Resident #27 was sitting in the dining room and was positioned far from the table. The resident was not eating or drinking.</p> <p>During observation on 5-2-12 at 1:10 p.m., CNA #2 brought Resident #27 from the dining room to dayroom. The resident's shirt and pants were wet and had liquid on them.</p> <p>During observation on 5-2-12 at 1:25 p.m., CNA #2 and CNA #3 assisted Resident #27 to the restroom. The resident's brief was soaked with dark urine and the urine had a strong odor. CNA #2 and CNA #3 agreed the resident's urine was dark and had a strong odor to it. CNA #3 indicated the resident did not drink much at lunch on this day.</p> <p>During interview with the Assistant Director Of Nursing (ADON) on 5-2-12 at 2:05 p.m., indicated there was not a plan of care in place for Resident #27 to prevent dehydration.</p>			

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	<p>During interview with the Wound Nurse on 5-2-12 at 2:10 p.m., she indicated Resident #27 should have a physician order for extra 120 ml of fluid a day and there was not a physician order for it. The Wound Nurse indicated CNA #3 had reported to her today that Resident #27 was not eating or drinking well, so she went to therapy and asked for the resident to be moved to the restorative table where staff would be sitting the resident.</p> <p>During interview with the MDS Coordinator on 5-2-12 at 2:20 p.m., the Coordinator indicated Resident #27 had a lot of recent changes. The MDS Coordinator indicated Resident #27 was at risk for dehydration and the facility would be putting the resident on a restorative dining program for 6 days a week for one meal a day. The MDS Coordinator indicated the Speech Therapist would be putting a plan of care in place for an eating and drinking program for Resident #27.</p> <p>During interview with the Dietician on 5-2-12 at 2:26 p.m., the Dietician indicated she had assessed Resident #27's fluid intake needs to be 1710 milliliters a day. The Dietician</p>			

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	<p>indicated the dietary department provided 1860 ml of fluid a day on the resident's meal trays. Review of Resident #27's fluid intake record with the Dietician at this time indicated she agreed the resident was not consuming enough fluid in a 24 hour period. The Dietician indicated nursing would be responsible to put a plan of care in place for dehydration.</p> <p>The fluid consumed for 5-2-12 at lunch for Resident #27 indicated the resident had 120 ml of fluid.</p> <p>Interview with the Director Of Nursing (DON) on 5-7-12 at 1:21 p.m., indicated the facility identifies and implements interventions for residents at risk for dehydration by a head to toe assessment when they are first admitted. The DON indicated all residents were on and intake and output when they are first admitted for 7 days and weekly weights for 4 weeks.</p> <p>The "HYDRATION MANAGEMENT PROGRAM" provided by the ADON on 5-7-12 at 9:15 a.m., indicated "All residents will receive appropriate interventions to support adequate hydration." The hydration standards were "At the time of admission, dietary will determine each resident's</p>						

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	<p>daily fluid needs." "A dehydration risk assessment will be completed by nursing within 10 days of admission." "A comprehensive care plan will be written after completion of the risk assessment." "A fluid plan to increase fluid intake will be put into place to reach the resident's daily fluid need, to include the resident preference." "Dietary will provide 1800 cc of fluid per day with meals, unless otherwise contraindicated." The "Education/Communication" indicated the licensed staff will inform direct care staff of residents at high risk or exhibiting signs of dehydration, along with the plan to promote fluid intake. The licensed staff will notify the physician of decreased fluid consumption. The licensed staff will alert dietary manager to risk of dehydration and confer in formulating a fluid plan. The resident if able and the family will be included in assessing, planning and intervention of controlling or eliminating risk, including providing for resident preferences on the plan of care.</p> <p>3.1-46(b)</p>				

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NAME OF PROVIDER OR SUPPLIER SYCAMORE SPRINGS REHABILITATION CENTRE	STREET ADDRESS, CITY, STATE, ZIP CODE 215 W HIGH ST LIBERTY, IN 47353
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F0329 SS=D	<p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on interview and record review, the facility failed to ensure indications for use were documented and non-pharmacological interventions were attempted prior to administration of Ativan (antianxiety medication) and failed to monitor the effects the medication had on the resident for 1 of 12 residents that met the criteria for antianxiety medication use (Resident #27).</p> <p>Finding include:</p>	F0329	F329 Requires the facility to ensure indications for use were documented and non-pharmacological interventions are attempted prior to admission of an antianxiety medication and will monitor the side effects. The facility will ensure this requirement is met through the following:1. Resident #27 was not harmed. Physician reviewed residents medications.2. All residents have the potential to be affected. All residents that were on a prn antianxiety medication had their	05/14/2012

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	<p>1.) Review of Resident #27's record on 5-1-12 at 3:30 p.m., indicated the resident's diagnoses included, but were not limited to, hypertension, Coronary Artery Disease (CAD), Chronic Renal Disease (CRD), Open area, osteoporosis, arthritis, Cerebral Vascular Accident (CVA), Chronic Obstructive Pulmonary Disease (COPD), anemia, Chronic Kidney Disease (CKD), dementia, anxiety, right pelvic fracture, depression and renal failure.</p> <p>The telephone physician order, dated 2-25-12, for Resident #27 indicated the resident was ordered Ativan 0.5 mg three times a day as needed for anxiety.</p> <p>The care plan for Resident #27, dated 3-28-12, indicated the resident requires Ativan for anxiety. The interventions included, but were not limited, administer medication as ordered, monitor for side effects, observe for change in mood or behavior. The care plan had no documentation of interventions to attempt to relieve the resident's anxiety prior to giving the medication.</p> <p>The February 2012 medication sheet</p>		<p>medication reviewed per the physician. 3. The antianxiety drug use policy and procedure was reviewed with no changes made. (See attachment H) The staff was inserviced on the above procedure.4. The DON or her designee will monitor to ensure at least two non-pharmacological interventions are tried prior to giving an antianxiety as well as an indication for use is documented when giving a prn antianxiety medication. The DON or designee will utilize the nursing monitoring tool for these audits daily times four weeks, weekly times four weeks, then every two weeks times two months, then quarterly thereafter until compliance is maintained.(See attachment B) The audits will be reviewed during the facility's quarterly quality assurance meetings and the plan of action will be adjusted accordingly.5. The above correction measures will be completed on or before May 14, 2012.</p>		

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	<p>for Resident #27 indicated the resident received Ativan 0.5 mg on 2-25-12, 2-26-12 and 2-28-12. There were no documented interventions attempted before administration or indication for the use of the Ativan. On 2-26-12, the resident was given Ativan 0.5 mg and indicated the resident had position change and "other" circled as interventions attempted before giving the medication, there were no documented indication for the use of the medication.</p> <p>The March 2012 medication sheet for Resident #27 indicated the resident received Ativan 0.5 mg on 3-3-12, 3-8-12, 3-10-12, 3-19-12, 3-20-12, 3-21-12, 3-22-12 and 3-24-12. The documentation indicated no interventions were attempted before administering the Ativan or any indication for the use of the Ativan.</p> <p>The April 2012 medication sheet for Resident #27 indicated the resident received Ativan 0.5 mg on 4-3-12, 4-4-12, 4-10-12, 4-11-12, 4-14-12, 4-16-12, 4-19-12, 4-26-12, 4-28-12 and 4-29-12. The documentation indicated no interventions were attempted before administering the Ativan or any indication for the use of the Ativan.</p>						

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NAME OF PROVIDER OR SUPPLIER SYCAMORE SPRINGS REHABILITATION CENTRE	STREET ADDRESS, CITY, STATE, ZIP CODE 215 W HIGH ST LIBERTY, IN 47353
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	<p>During interview with Social Service Director (S.S.D.) on 5-3-12 at 10:25 a.m., the SSD indicated she kept communication forms at the nursing station and outside her door for staff to fill out if a resident is having any problems. "The staff are supposed to put them in my box and I take them to morning meeting and review them with Director Of Nursing (DON). The DON then signs off on communication form. During morning meeting the staff talk about what works for a resident who is having problems. The staff discuss what might be going on with the resident and why the behavior may be happening." The S.S.D. indicated they discussed if it was a new behavior and see if there was pattern to the problem. The S.S.D. indicated Resident #27 had no documented behaviors in February 2012 and in March 2012. She had two episodes of confusion and one episode of turning her alarm off. The resident had one behavior of being tearful in April 2012 and the intervention was assisted the resident to a quiet environment. "When the nurse gives a PRN (as needed) Ativan they are supposed to fill out a mood and behavior memo that tells what the behavior was and what</p>			

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	<p>intervention were attempted before the medication was given and if the were successful." The S.S.D. indicated there were no documented behavior memos filled out for Resident #27 receiving Ativan.</p> <p>Interview with the S.S.D. on 5-3-12 at 10:50 a.m., indicated Resident #27 was not being seen by psychiatric services.</p> <p>The "ANTIAXIETY DRUG USE POLICY" provided by the Wound Nurse on 5-7-12 at 11:45 a.m., indicated the purpose of the policy was to ensure that antianxiety drugs will be administered only when medically indicated to treat a specific condition and help promote or maintain the resident's highest practicable mental, physical, and psychosocial well being. Non-pharmacological interventions will be considered and used when indicated, instead of, or in addition to, medication.</p> <p>3.1-48(a)(3) 3.1-48(a)(4)</p>				

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F0356 SS=C	<p>483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis:</p> <ul style="list-style-type: none"> o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: <ul style="list-style-type: none"> - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. <p>The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows:</p> <ul style="list-style-type: none"> o Clear and readable format. o In a prominent place readily accessible to residents and visitors. <p>The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.</p> <p>The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.</p> <p>Based on observation, interview, and record review, the facility failed to ensure the daily licensed nurse staff posting information only reflected the licensed nursing staff directly responsible for resident care, for 2 of</p>	F0356	F356 Requires the facility to ensure daily licensed nurse staff posting information only reflects the licensed nursing staff directly responsible for care. The facility will ensure this requirement is met through the following:1. No	05/14/2012			

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	<p>5 survey days observed, and failed to ensure the nurse staff posting information was in an area visible to the public and residents, for 1 of 5 survey days observed.</p> <p>This had the potential to affect all residents and their visitors,</p> <p>Findings include:</p> <p>An initial tour of the facility on 4/30/12 at 9:19 A.M., the Nurse Staff posting was observed high on the wall of the nurses station. Review of the Nurse Staff posting indicated day shift had 2 RN's and 2 LPN's. An interview at that time with the Director of Nursing (DoN) indicated she had 1 LPN and 1 RN assigned to direct resident care for day shift.</p> <p>An interview with the DoN on 4/30/12 at 10:15 A.M., indicated herself and the Assistant Director of Nursing (ADON) were included on the Nurse Staff posting because they helped on the floor.</p> <p>An observation of the Nurse Staff posting on 5/1/12 at 8:30 A.M., indicated day shift had 1 RN and 3 LPN's. An interview with the DoN at that time indicated the ADON had been included on the posting. The DoN indicated the ADON was not</p>		<p>resident was harmed.2. All residents have the potential to be affected.3. The nursing daily staffing posting policy and procedure was reviewed with no changes.(See attachment I) The staff was inserviced on the above procedure.4. The DON or her designee will review the hours posted and ensure that only nursing hours are posted of nursing staff that provide direct care for a resident. The DON or her designee will utilize the nursing monitoring tool daily times four weeks, weekly times four weeks, then every two weeks times two months, then quarterly thereafter until compliance is maintained.(See attachment B) The audits will be reviewed during the facility's quarterly quality assurance meetings and the plan of action will be adjusted accordingly.5. The above corrective measures will be completed on or before May 14, 2012.</p>				

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	<p>assigned to direct resident care but would be helping on the floor if needed.</p> <p>3.1-13(a).</p>			