

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155511	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/26/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  TERRE HAUTE NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 830 S 6TH ST TERRE HAUTE, IN 47807
---	--

(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
--------------------	--	---------------	---	----------------------

F 0000  Bldg. 00	<p>This visit was for the Investigation of Complaints IN00207765 and IN00208500. This visit resulted in a Partially Extended Survey-Immediate Jeopardy.</p> <p>Complaint IN00207765 - Substantiated. Federal/State deficiencies related to the alleations are cited at F282, and F309.</p> <p>Complaint IN00234567 - Substantiated. No deficiencies related to the allegations are cited.</p> <p>Unrelated deficiencies are cited.</p> <p>Survey dates: August 24, 2016 Extended dates: August 25 and 26, 2016</p> <p>Facility number: 000446 Provider number: 155511 AIM number: 100288720</p> <p>Census bed type: SNF/NF: 27 Total: 27</p> <p>Census payor type: Medicare: 4 Medicaid: 17 Other: 6</p>	F 0000		
------------------------	--	--------	--	--

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155511	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/26/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  TERRE HAUTE NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 830 S 6TH ST TERRE HAUTE, IN 47807
---	--

(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
--------------------	--	---------------	---	----------------------

F 0282 SS=D Bldg. 00	<p>Total: 27</p> <p>Sample: 7 Extended sample: 7</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality Review was completed by 21662 on August 30, 2016.</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on record review and interview, the facility failed to ensure post fall neuro checks were completed for 1 of 3 residents reviewed for falls. (Resident E). Finding includes: Resident E's record was reviewed on 8/26/16 at 10:15 a.m. An Incident Report dated 8/15/16, indicated the resident lost his balance while walking in his room, fell backwards landing on his bottom. The</p>	F 0282	<p>F282</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p>	09/25/2016
----------------------------	--	--------	---	------------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155511	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/26/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  TERRE HAUTE NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 830 S 6TH ST TERRE HAUTE, IN 47807
---	--

(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>report indicated the resident indicated his head hit on his dresser. The resident sustained a 4cm (centimeter) x 4cm raised area on the back of his head with a 2cm x 2cm abrasion in the center of the raised area. The report indicated 10 hours of post fall neuro checks were completed (15 minutes x 4, every 30 minutes x 2, and every 4 hours x 2, over a less than 24 hour time period).</p> <p>The resident's quarterly Fall Assessment dated 3/1/16, indicated the resident was at risk for falls.</p> <p>A care plan dated 2/6/15 and updated on 3/1/16, indicated the resident had the potential for falls. Interventions included, but were not limited to, keep the resident's call light within reach and encourage the resident to use the call light when he needed assistance, use a rolling walker during ambulation, and follow facility fall protocol.</p> <p>During an interview on 8/26/16 at 10:49 a.m., the DON (Director of Nursing) indicated the post fall neuro checks were to be completed over a 72 hour period after the fall event.</p> <p>On 8/26/16 at 2:16 p.m., an undated policy, titled " Neuro Evaluation Time Frames, " identified as current, was provided by the DON. The policy indicated, " 1. Every 15 minutes times 1</p>		<p><b>How will the corrective action be accomplished for those residents who are affected by this alleged deficient practice?</b></p> <p>-All nurses that were assigned to care for the res "E" during the 72 hour period post fall were</p> <p>given disciplinary action for not completing neurological checks for 72 hours per facility policy.</p> <p><b>How will the facility identify resident having the potential to be affected by the same deficient practice?</b></p> <p>-All residents have the potential to be affected although none were identified.</p> <p><b>What measures were put into place or systematic changes made to ensure that the deficient practice not recur?</b></p> <p>-All licensed nursing staff were in-serviced on the neuro evaluation time frame and the neurological assessment policy by David Tucker RN, DON</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155511	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/26/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  TERRE HAUTE NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 830 S 6TH ST TERRE HAUTE, IN 47807
---	--

(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
F 0309 SS=D Bldg. 00	<p>hour, then, 2. Every 30 minutes times 1 hour, then, 3. Every hour times 2 hours, then, 4. Every 4 hours until 72 hours post event. "</p> <p>A policy, titled, "Neurological Assessment," revised 2002, was provided by the Administrator on 8/26/16 at 2:40 p.m. The policy indicated, "General Guidelines, 1. Neurological assessments are indicated: ...b. Following an unwitnessed fall; c. Following a fall or other accident/injury involving head trauma...."</p> <p>This Federal tag relates to complaint IN00207765.</p> <p>3.1-35(g)(2)</p> <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</p>		<p><b>How will the facility monitor its corrective actions?</b></p> <p>-The DON/Designee will monitor all fall documentations to assure neuro checks are completed per facility policy. Any deficient areas will be addressed immediately.</p> <p>-The DON/Designee will report to the Administrator in the Daily QA meeting any unwitnessed fall, fall or other accident/injury involving known or possible head trauma.</p> <p>-The QA Committee will review falls/incidents/accidents involving known or possible head trauma at the scheduled meetings with recommendations for additional interventions as needed.</p> <p><b>Date the deficiency will be corrected?</b></p> <p>-September 25, 2016</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155511	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/26/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  TERRE HAUTE NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 830 S 6TH ST TERRE HAUTE, IN 47807
---	--

(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>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 thoroughly monitor and assess a resident's condition following a fall with head injury, for 1 of 2 residents reviewed for falls with head injury. (Resident B)</p> <p>Finding includes:</p> <p>On 8/24/16, at 9:30 a.m., Resident B was observed in bed. A bruise was noted on the right side of his face and head. The resident indicated he had fallen from the bed.</p> <p>Certified Nursing Assistant (CNA #10) was interviewed on 8/24/16 at 9:24 a.m. The CNA indicated she had reported the resident's lack of intakes to a nurse prior to 8/10/16.</p> <p>Resident B's record was reviewed on 8/24/16 at 10:20 a.m. An annual Minimum Data Set (MDS) assessment, dated 7/27/16, coded the resident with a brief interview for mental status (BIMS) of severe cognitive impairment, and required only set up and supervision for eating.</p> <p>A plan of care included, but was not</p>	F 0309	<p><b>F309</b></p> <p><b>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</b></p> <p><b>EACH RESIDENT MUST RECEIVE AND THE FACILITY MUST PROVIDE NECESSARY CARE AND SERVICES TO ATTAIN OR MAINTAIN THE HIGHEST PRACTICABLE PHYSICAL, MENTAL, AND PSYCHOSOCIAL WELL BEING, IN ACCORDANCE WITH THE COMPREHENSIVE ASSESSMENT AND THE PLAN OF CARE</b></p> <p><b>How will the corrective action be accomplished for those residents who are affected by this alleged deficient practice?</b></p> <p>-All licensed nursing were given a teachable moment on the facility policy of Change in Resident</p> <p>Condition or Status and Physician Notification by David Tucker RN, DON</p>	09/25/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155511	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  08/26/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  TERRE HAUTE NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 830 S 6TH ST TERRE HAUTE, IN 47807
---	--

(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>limited to, with most recent revision date of 7/26/16, "Resident is at nutritional risk inadequate/excessive intake....leaves 25 percent or more of food uneaten at most meals".... Interventions included, but were not limited to: monitor lab/diagnostics as available and make recommendations as needed, offer substitutions if 50 percent or less is consumed.</p> <p>A nursing note dated 8/8/16 at 7:05 a.m., indicated the resident had been ambulating to the dining room, and fell on the floor. He was found on his right side. A 11.5 centimeter (cm) laceration to the right temporal area was noted. Vital signs and neuro checks were implemented and were within normal range.</p> <p>A nursing note dated 8/8/16 at 1:30 p.m., indicated the resident complained of right sided rib pain, very tender to touch. A portable x-ray was obtained and the results were negative for fractured ribs.</p> <p>A fall follow up report on 8/9/16 at 6:00 a.m., indicated the resident had vomited a small amount of light, brown, fluid.</p> <p>A nursing note dated 8/10/16 at 6:10 p.m., indicated Certified Nursing Assistant (CNA #10) had reported the</p>		<p><b>How will the facility identify residents having the potential to be affected by the same deficient practice?</b></p> <p>-All residents have the potential to be affected although none were identified.</p> <p><b>What measure will be put into place or systematic changes were made to ensure that the deficient practice not recur?</b></p> <p>-All Nursing and Dietary staff were in-serviced by David Tucker RN, DON on communicating and documenting all residents daily nutritional intake and to report any concerns to the Charge Nurse/DON immediately.</p> <p>-All licensed Nursing staff in-serviced by David Tucker RN, DON will report any significant variations in usual eating/intake patterns to the resident's physician and Clinical Dietician.</p> <p><b>How will the facility monitor its corrective actions?</b></p> <p>-All Nursing &amp; Dietary staff will document resident food/fluid intake after each meal/snack in</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155511	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  08/26/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  TERRE HAUTE NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 830 S 6TH ST TERRE HAUTE, IN 47807
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>resident had not had any intake for the day, had an increase in confusion, and tremors which was new for the resident. The physician was notified and the resident had been transported to the hospital. The resident was admitted to the hospital with diagnoses of subdural hematoma, delirium, and urinary tract infection. No surgical intervention could be done.</p> <p>The "Meal Consumption," record for the resident, reviewed on 8/25/16 at 3:30 p.m., indicated on 8/8/16, the resident refused all nutritional and fluid intakes. On 8/9/16, the resident refused all except 240 cc fluid intake, and no intake on 8/10/16, prior to being transferred to the hospital at 7:51 p.m.</p> <p>Abnormal lab results obtained in the hospital on 8/10/16, included, but were not limited to, sodium, potassium, chloride, blood urea nitrogen, creatinine, red blood cell count, hemoglobin, and hematocrit levels.</p> <p>A facility policy titled "Change in a Resident's Condition or Status", revised August, 2006, provided by the Director of Nursing (DON) as current on 8/25/16 at 2:30 p.m., included, but was not limited to, "Our facility shall promptly notify the resident, his or her Attending</p>		<p>the Meal Consumption Book and report any significant change in the resident's food/fluid intake pattern.</p> <p>-DON/Designee will monitor Meal Consumption Book documentation 3x's weekly, 1x monthly, then weekly x 5 months and contact Clinical Dietician if necessary.</p> <p>-The DON/Designee will report to the Administrator any significant variations in resident food/fluid intake patterns.</p> <p>-The QA Committee will review meal consumption documentation at the scheduled meetings with recommendations for additional interventions as needed.</p> <p><b>Date the deficiency will be completed?</b></p> <p>-September 25, 2016</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155511	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/26/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  TERRE HAUTE NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 830 S 6TH ST TERRE HAUTE, IN 47807
---	--

(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>Physician, and representative (sponsor) of changes in the resident's medical/mental condition and/or status...Policy Interpretation and Implementation 1. The Nurse Supervisor/Charge Nurse will notify the resident's Attending Physician or On-Call Physician when there has been:...d. A significant change in the resident's physical/emotional/mental condition; e. A need to alter the resident's medical treatment significantly"....</p> <p>A facility policy titled "Resident Nutrition Services" revised December 2007, provided by the Administrator as current on 8/26/16 at 3:00 p.m., included but was not limited to, "Intake Reports ...7. Nursing personnel should evaluate food and fluid intake in residents with, or at risk for, significant nutritional problems. Nursing staff will assess and document the amounts eaten as indicated for individuals with, or at risk for, impaired nutrition. Intake Pattern Variations 8. Significant variations from usual eating or intake patters must be recorded in the resident's medical record. The Nurse Supervisor and/or Unit Manager shall evaluate the significance of such information and report it, as indicated, to the Attending Physician and Clinical Dietitian"....</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155511	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  08/26/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  TERRE HAUTE NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 830 S 6TH ST TERRE HAUTE, IN 47807
---	--

(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
F 0323 SS=J Bldg. 00	<p>A facility policy titled "Resident Nutrition Services", dated December 2007, provided by the Administrator on 8/26/16 at 2:35 p.m., and identified as current, included but was not limited to: "General Guidelines...5. At the end of your shift, total the amounts of all liquids the resident consumed. 6. Record all fluid intake on the intake and output record in cubic centimeters (mls)..."</p> <p>This Federal tag relates to complaint IN00207765.</p> <p>3.1-37(a)</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record review, the facility failed to ensure mechanical lift slings were inspected and maintained according to manufacture's directions to prevent a strap on a sling from breaking resulting in Resident F</p>	F 0323	<b>F323 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES THE FACILITY MUST ENSURE THE RESIDENT ENVIRONMENT REMAINS AS FREE OF ACCIDENT HAZARDS</b>	09/25/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155511	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  08/26/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  TERRE HAUTE NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 830 S 6TH ST TERRE HAUTE, IN 47807
---	--

(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>falling from a lifted position to the floor and hurting his back. This deficient practice had the potential to affect 6 of 6 residents who used mechanical lifts (Residents F, H, I, J, K, and L).</p> <p>The Immediate Jeopardy began on 08/24/16 when Resident F fell from a lifted position to the floor. The Administrator and Director of Nursing (DON) were notified of the Immediate Jeopardy on 8/24/16 at 3:30 p.m.</p> <p>Findings includes:</p> <p>1. On 8/24/16 at 1:25 p.m., during an interview with CNA #1, the CNA indicated a hoyer lift sling had broken that day and Resident F fell to the floor.</p> <p>On 8/24/16 at 1:45 p.m., Laundry Staff #2 was interviewed. She indicated slings should be hung to dry, and bleach was not to be used.</p> <p>On 8/24/16 at 2:00 p.m., with the DON, seven lift slings were observed. Three of the seven had either frayed, or ripped parts of the slings. The sling, that had been utilized for Resident F, was observed. A double strap had broken and tore apart from the sling. The edges of the straps were frayed and the care label was faded and not legible. An odor of</p>		<p><b>AS IS POSSIBLE; AND EACH RESIDENT RECEIVE ADEQUATE SUPERVISION AND ASSISTANCE DEVICES TO PREVENT ACCIDENTS. How will the corrective action be accomplished for those residents who are affected by this alleged deficient practice?</b></p> <p>-All hoyer slings were inspected for condition. Any sling with obvious defect was immediately removed from resident use and replacements were ordered. -All hoyer slings in good condition were numbered for identifications/inspection purposes -All Maintenance, Laundry, and Nursing staff were in-serviced by Jodi Sanders, Administrator on policy titled "Safe Lifting &amp; Movement of Residents prior to the start of scheduled shifts -All Nursing staff were in-serviced by David Tucker RN, DON and Jodi Sanders, Administrator in regards to inspecting all hoyer slings prior to be being used. Any defects are to be immediately reported to the DON/Administrator, the sling will be removed from use. -All Laundry and Nursing Staff were in-serviced by Jodi Sanders, Administrator and Gifty Dadzie Laundry/Housekeeping Supervisor on the proper washing/drying/general care of all hoyer slings. Any defects are to be immediately reported to the DON/Administrator and the sling will be removed from service -All</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155511		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED  08/26/2016	
NAME OF PROVIDER OR SUPPLIER  TERRE HAUTE NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 830 S 6TH ST TERRE HAUTE, IN 47807			
(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>bleach was noted on the slings.</p> <p>On 8/24/16 at 2:05 p.m., the DON was interviewed. He indicated laundry used bleach at times on the slings even though they had been instructed not to. He further indicated the facility did not have a policy regarding safety checks and laundering of the slings. He indicated he was in the process of developing one.</p> <p>On 8/24/16 at 2:30 p.m., LPN #3 was interviewed. She indicated she had received report from the hospital and the resident was going to be sent back to the facility with a diagnosis of lumbar fracture. A hospital report, dated 8/24/16 at 1:22 p.m., included, but was not limited to, "5. L1 [first vertebrae of the lumbar spine] compression fracture probably chronic. Old healing right lateral seventh and eighth rib fractures."</p> <p>On 8/24/16 at 3:19 p.m., CNA #1 was interviewed a second time. She indicated she performed the transfer with assistance from LPN #3. The CNA indicated the strap on the lift sling broke when the resident was being transferred from the chair to his bed. The resident fell from the raised position to the floor.</p> <p>LPN #3 was interviewed on 8/24/16 at 3:23 p.m. She indicated she had not</p>		<p>Laundry staff were in-serviced and are to document the numbered sling and its conditions prior to washing. -All mechanical hoier lifts will be inspected and documented monthly by facility Maintenance, will immediately remove mechanical hoier lift from service and notify Administrator if any defects are found. -C.N.A. #1 and LPN #3 were suspended pending investigation and retrained on identification of worn, unusable hoier slings prior to return to duty - A list will be kept and updated a minimum of monthly by the DON/Designee of each resident using a sling, and it will be available at all times for reference <b>How will the facility identify residents having the potential to be affected by the same deficient practice?</b> -7 residents were identified as having the potential to be affected although 6 residents were not.</p> <p><b>How will the facility monitor its corrective actions?</b></p> <p>-DON/Administrator will monitor mechanical lift sling inspection logs placed in the laundry area Weekly. -The DON/Administrator will monitor mechanical lift transfer logs daily x 1 week, weekly x1 Month and no less then monthly thereafter.</p> <p>-All new staff upon hire will be in-serviced on "Safe Resident Lifting &amp; Moving of Resident" Policy and the washing/drying and general care of hoier slings.</p> <p>-DON/Administrator will perform</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155511	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/26/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  TERRE HAUTE NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 830 S 6TH ST TERRE HAUTE, IN 47807
---	--

(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>checked the sling as it had been under the resident in his wheelchair when he was up for breakfast. She indicated, after breakfast, he was transferred back to bed which is when the fall occurred.</p> <p>Resident F's record was reviewed on 8/24/16 at 4:00 p.m. An initial admission date of 8/5/16 was noted. Diagnoses included, but were not limited to, morbid obesity, right below the knee amputation, and left foot amputation.</p> <p>An Minimum Data Set (MDS) assessment, dated 8/11/16, coded the resident as non-ambulatory, required extensive assistance of two for transfers. An initial plan of care, dated 8/5/16, addressed the resident was at risk of injury from falls related to amputation and required the assistance of two for mechanical lift transfers.</p> <p>A "Skilled Nursing Intake Form," dated 8/24/16 at 8:15 a.m., included "This writer was spotting CNA while CNA was transferring res [resident] from w/c [wheelchair] to bed with Hoyer lift. Strap on hoyer broke et [and] Res slid out of hoyer sling and landed on floor on right side. Head did not hit the floor. Res c/o [complained of] lower back et [and] leg pains. Transcare notified of need to transfer Res from [facility name]</p>		<p>random inspections of all hoyer slings x2 monthly. -The QA Committee will review resident requiring mechanical lift transfers weekly until 100% compliance is achieved and then at the scheduled meetings with recommendations for additional interventions as needed. <b>Date the deficiency will be corrected?</b> -September 25, 2016</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155511	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/26/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  TERRE HAUTE NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 830 S 6TH ST TERRE HAUTE, IN 47807
---	--

(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>to hospital [name] emergency room for eval [evaluation] et tx [treatment]. Res mother notified. On 8/24/16 at 8:40 a.m. resident transported to hospital."</p> <p>2. Resident L's clinical record was reviewed on 8/25/16 at 8:25 a.m. The resident had been identified by LPN #4 on 8/24/16 at 2:45 p.m., as utilizing a hoyer lift. The resident's diagnosis included, but was not limited to, anxiety, seizures, breast cancer, Schizoaffective disorder. A quarterly Minimum Data Set (MDS) assessment dated 7/10/16, coded the resident with severe cognitive impairment, required extensive assistance of two for bed mobility and transfers, was non-ambulatory and utilized a wheelchair. The resident's weight was 197. A plan of care, dated 7/2/16, addressed the potential for falls related to receiving psychotropic medications and was dependent on staff for all care needs. An approach was added on 8/25/16, of may use hoyer lift to transfer as needed for safety of resident and staff. Follow policy for care and checks of sling to use with hoyer.</p> <p>3. Resident K's clinical record was reviewed on 8/25/16 at 8:37 a.m. The resident had been identified by LPN #4 on 8/24/16 at 2:45 p.m., as utilizing a hoyer lift. Diagnoses included, but was</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155511	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/26/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  TERRE HAUTE NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 830 S 6TH ST TERRE HAUTE, IN 47807
---	--

(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>not limited to, dementia, Parkinson's, anemia, Schizophrenia, bipolar, and anxiety. A quarterly MDS dated 7/19/16, coded the resident with a Brief Interview of Mental Status (BIMS) of 6, severe cognitive impairment. The resident required extensive assistance of two for bed mobility and transfers, was non-ambulatory. The resident utilized a wheelchair and had no falls. The resident's weight was 193. A plan of care, dated 2/1/15, addressed a self care deficit related to limited mobility, up in broda chair and locomotion per staff. An approach was added on 8/25/16, may use hoyer lift for transfers for fall safety of residents and staff.</p> <p>4. Resident J's record was reviewed on 8/25/16 at 12:24 p.m. Diagnoses included, but were not limited to, aphasia and CVA (cerebral vascular accident). An annual MDS assessment, dated 4/26/16, indicated the resident required total dependence of 2 persons for transfers. LPN #4 indicated in an interview on 8/24/16 at 2:45 p.m. the resident used a mechanical lift for transfers. A care plan, dated 8/25/16, indicated the resident required a hoyer lift for transfers.</p> <p>5. Resident I's record was reviewed on 8/25/16 at 12:28 p.m. Diagnosis</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155511	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/26/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  TERRE HAUTE NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 830 S 6TH ST TERRE HAUTE, IN 47807
---	--

(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>included, but was not limited to, CVA (cerebral vascular accident). A quarterly MDS assessment, dated 7/31/16, indicated the resident required transfer assistance of 2 persons. In an interview on 8/24/16 at 2:45 p.m., LPN #4 indicated the resident used a hooyer lift for transfers. A care plan, initiated 2/17/15 and revised 8/24/16, indicated the resident required a hooyer lift for transfers.</p> <p>6. Resident H's record was reviewed on 8/25/16 at 12:31 p.m. Diagnoses included, but were not limited to dementia, COPD (chronic obstructive pulmonary disease) and heart failure. A 60 day MDS assessment, dated 7/29/16, indicated the resident was total dependence for transfers. LPN #4 indicated on 8/24/16 at 2:45 p.m. the resident required a hooyer lift for transfers. A care plan, initiated 12/5/13 and updated 8/25/16, indicated the resident required a hooyer lift for transfers.</p> <p>Manufacture's directions for the hooyer lift were provided by the Administrator on 8/24/16 at 3:30 p.m. She indicated she printed them off from the web site. They included, but were not limited to: "CARE NOTE: Laundering should always be done with dark colors. The sling should be washed regularly in a water temperature not to exceed 180</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155511	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  08/26/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  TERRE HAUTE NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 830 S 6TH ST TERRE HAUTE, IN 47807
---	--

(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>degrees F [Fahrenheit] (82 degrees C [Celsius]. DO NOT bleach. Air dry or dry at low temperature. Inspect with each use. Refer to tagged washing instructions on the sling. WARNING After each laundering (in accordance with instructions on the sling), inspect sling(s) for wear, tears, and loose stitching. Bleached, torn, cut, frayed, or broken slings are unsafe and could result in injury. Discard immediately."</p> <p>The immediate jeopardy that began on 8/24/16 was removed on 8/25/16 when the facility assessed all slings of the facility and disposed of slings, not in safe condition. A policy titled "The Safe Lifting and Movement of Resident's" policy was implemented and maintenance, laundry, and nursing staff were in-serviced prior to start of scheduled shifts. Adherence to the policy will be supervised by the Administrator daily times one week, weekly times one month, and no less than monthly thereafter but the noncompliance remained at the lower scope and severity level of no actual harm with the potential for more than minimal harm that is not immediate jeopardy because of the facility need for continued monitoring and inservicing of two employees.</p> <p>3.1-45(a)(1)</p>			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/20/2016

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155511	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 08/26/2016
NAME OF PROVIDER OR SUPPLIER  TERRE HAUTE NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 830 S 6TH ST TERRE HAUTE, IN 47807		
(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	