

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155441	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/25/2014
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NAME OF PROVIDER OR SUPPLIER  CORYDON NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 315 COUNTRY CLUB RD CORYDON, IN 47112
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F000000	<p>This visit was for Investigation of Complaint IN00150797.</p> <p>Complaint IN00150797 - Substantiated - Federal/State deficiencies related to the allegations are cited at F157 and F309.</p> <p>Survey date: June 24 and 25, 2014</p> <p>Facility number: 000338 Provider number: 155441 AIM number: 100287590</p> <p>Survey team: Gloria J. Reisert MSW</p> <p>Census bed type: SNF/NF: 29 Total: 29</p> <p>Census payor type: Medicare: 05 Medicaid: 20 Other: 04 Total: 29</p> <p>Sample: 4</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality Review completed on June 30,</p>	F000000	By submitting the enclosed material we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests that the plan of correction be considered our allegation of compliance effective July 16, 2014 to the complaint survey conducted on June 25, 2014.	

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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F000157 SS=D	<p>2014, by Brenda Meredith, R.N.</p> <p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p>				

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	<p>Based on record review and interviews, the facility failed to ensure the primary physician was notified of lab results for one of three residents reviewed for weights. (Resident A) The facility also failed to ensure the physician was notified of weight gain/loss for 2 of 3 residents reviewed for weights. (Resident B and Resident C).</p> <p>Findings include:</p> <p>1. Review of the clinical record for Resident #A on 6/24/14 at 9:45 a.m., indicated the resident had diagnoses which included, but were not limited to: chronic kidney disease Stage 3, congestive heart failure, hypertension and pulmonary heart disease.</p> <p>A 5/9/14 at 8:45 p.m., nursing note indicated: "Rec'd [received] lab results...On-call MD, [name of physician] notified &amp; rec'd N.O. to notify [name of primary physician] of BUN [blood, urea, and nitrogen - chemicals in the body] &amp; Creatinine on Monday 5/12/14..." Documentation was lacking of the primary physician having been notified of the lab results.</p> <p>Interviews were conducted with RN #1 on 6/25/14 at 8:20 a.m. and LPN #1 on 6/25/14 at 9:45 a.m. They indicated were</p>	F000157	<p>By submitting the enclosed material we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests that the plan of correction be considered our allegation of compliance effective July 16, 2014 to the complaint survey conducted on June 25, 2014. <b>F-157 It is the practice of this facility to assure that a resident's physician is notified of both lab results and weight gain/loss.</b> What corrective actions will be accomplished for those residents found to have been affected by the deficient practice: Resident A was readmitted from hospital on 7/8/14 and is in process of being assessed. Resident C no longer resides in facility. Resident D's primary physician is aware of the resident's weight gain. <b>How you will identify other residents having potential to be affected by the same practice and what corrective action will be taken:</b> All residents have had weights reviewed as well as labs to assure that the physician has been notified appropriately in accordance with the regulation. <b>What measures will be put into place or what systematic changes you will make to ensure that the practice does</b></p>	07/16/2014			

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	<p>not sure if the primary physician had been notified of the lab results.</p> <p>On 6/24/14 at 12:00 p.m., the Administrator presented a copy of the facility's current policy titled "Change in a Resident's Condition or Status". Review of this policy at this time included, but were not limited to: "Our facility shall notify the resident, his or her Attending Physician, and representative 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:...c. A significant change in the resident's physical/emotional/mental condition...j. Instructions to notify the physician of changes in the resident's condition..."</p> <p>2. Review of the clinical record for Resident #C on 6/25/14 at noon, indicated the resident was admitted to the facility on 3/12/14 and had diagnoses which included, but were not limited to: hypertension (high blood pressure) and toxic metabolic encephalopathy.</p> <p>3/12/14 Admitting orders indicated weekly weights times 4 weeks were to be done. Upon return from the hospital on 4/24/14, orders again were received for</p>		<p><b>not recur:</b> All nurses will be in-serviced related to assuring that all labs are reported appropriately to the physician. The training also includes assuring that the primary physician is made aware of the results as well. In addition, the in-service covers assuring that physicians are notified of weight gain/loss in accordance with the facility policy. The nurses are responsible for assuring that the resident's physician is notified appropriately of significant changes. Please see below for means of monitoring. <b>How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put into place:</b> A Performance Improvement Tool has been initiated that will randomly reviews 5 residents related to lab values and weight gain/loss. The tool will review for proper physician notification. The Director of Nursing, or designee, will complete this audit weekly x3, monthly x3, and then quarterly x3. Any issue identified will be immediately corrected. The Quality Assurance Committee will review the tool at the scheduled meeting following the completion of the tool with recommendations as needed based on the outcome of the audit. <b>Date of compliance:</b> 7-16-14</p>				

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	<p>weekly weights until 5/26/14 when a new order for monthly weights was received.</p> <p>On 6/24/14 at 12:17 p.m., RN #1 presented the resident's Monthly Weight History report and on 6/25/14 at 11:00 a.m., presented the Weight History report from admission to 6/18/14.</p> <p>Review of these histories indicated the following weights:</p> <ul style="list-style-type: none"> <li>- March 13 = 139.4 pounds</li> <li>- March 17 = 138.60 pounds</li> <li>- April 6 = 147.4 pounds - a 8.6 pound gain</li> <li>- April 25 = 156.2 pounds - a 10.8 pound gain</li> <li>- April 28 = 156.2 pounds</li> <li>- May 4 = 153.8 pounds</li> <li>- June 18 = 131 pounds - a loss of 22.8 pounds.</li> </ul> <p>Documentation was lacking of the physician and/or family having been notified of these significant weight fluctuations as well as the difficulty the staff were having in obtaining the weights; a re-weight having been done to verify the accuracy of the weight, as well as an assessment as to causative factors for the fluctuations.</p> <p>During an interview with RN #1 on 6/25/14 at 2:15 p.m., she indicated that</p>				

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	<p>the resident had a tendency to be very combative a lot of times and that the CNAs (Certified Nursing Assistants) were unable to get his weight as ordered but had no documentation of this and was not sure if the staff tried to get the weight at another time. She also indicated that she was not aware of any facility protocol for notifying the physician when there were significant weight fluctuations.</p> <p>3. Review of the clinical record for Resident #D on 6/24/14 at 12:25 p.m., indicated that the resident had diagnoses which included, but were not limited to: Alzheimer's dementia and hypertension (high blood pressure).</p> <p>On 6/3/10, a physician's order for Monthly weights was received.</p> <p>On 6/24/14 at 12:14 p.m., RN #1 presented the monthly weights between January 2014 and March 2014. Review of these weights at this time indicated the following:</p> <ul style="list-style-type: none"> <li>- January = 185.2</li> <li>- February = 188.0 - gain of 2.8 pounds</li> <li>- March = 196.4 - gain of 8.4 pounds</li> </ul> <p>Documentation was lacking of the physician and/or family having been notified of the weight gain.</p>			

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	<p>On 6/24/14 at 1:00 p.m., RN #1 presented a copy of the facility's current policy titled "Weekly Weights (SOC) [Standards of Care]". Review of this policy at this time included, but was not limited to: "Standard: Based on a resident's comprehensive assessment, the facility must ensure a resident maintains acceptable parameters of nutritional status, such as body weight...; unless the resident's clinical condition demonstrates that is not possible/ Guidelines:...The Director of Nursing or designee will be responsible for comparing weekly weight to the weight recorded the previous week. Any weight variance of three (3) pounds gain or loss within the past 7 days requires a reweigh within 24 hours. 5. The Director of Nursing or designee will be responsible for notification of the Dietary department, the resident's attending physician, and the resident and/or family member of the weight loss or gain."</p> <p>This Federal tag is related to Complaint IN00150797.</p> <p>3.1-5(a)(2)</p>			

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F000309 SS=D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>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 record review and interviews, the facility failed implement the plan of care for weight monitoring by obtaining physician-ordered daily and weekly weights; do immediate re-weights when weights exceeded 3 pounds from the previously obtained weight; assess the residents when significant weight gains were recorded; and consult with the family/resident on pursuing an alternate nephrologist (Kidney Physician) when the requested one declined care. This deficient practice affected 3 of 4 residents reviewed for weight monitoring in a sample of 4. (Residents #A, C, and D)</p> <p>Findings included:</p> <p>1. Review of the clinical record for Resident #A on 6/24/14 at 9:45 a.m., indicated the resident had diagnoses which included, but were not limited to: chronic kidney disease Stage 3, congestive heart failure (CHF), hypertension, diabetes and pulmonary</p>	F000309	<p><b>F-309 It is the practice of this facility to assure that each resident receives the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being.</b></p> <p>What corrective actions will be accomplished for those residents found to have been affected by the deficient practice: Resident A returned from hospital on 7/8/14 and is in process of being assessed. Will approach resident to determine wishes to see a different nephrologist. Resident C no longer resides in facility. Resident D's primary physician is aware of the resident's weight gain. <b>How you will identify other residents having potential to be affected by the same practice and what corrective action will be taken:</b></p> <p>All residents have had weights reviewed to assure the physician has been notified appropriately in accordance with the regulation of any weight fluctuations. In addition, per the review, there were no other residents identified that had been refused to be seen</p>	07/16/2014			

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	<p>heart disease.</p> <p>Upon return from the hospital on 3/8/14, the resident had physician orders to be weighed weekly.</p> <p>On 6/24/14 at 12:17 p.m., RN #1 presented a copy of the resident's Monthly Weight Report. Review of this report and the nursing notes between 3/8/14 and 6/10/14, the following entries were made of the resident's weight:</p> <ul style="list-style-type: none"> <li>- February = 309.8 pounds</li> <li>- March 3 = 324.6 - a gain of 15.5 pounds</li> <li>- March 16 = 323.2 pounds</li> <li>- April 6 = 316.8 - a loss of 6.4 pounds</li> <li>- May 9 = 326.4 - a gain of 9.6 pounds</li> <li>- May 13 = 330 pounds - a gain of 3.6 pounds (Physician was notified of weight gain and new orders for Bumex - a diuretic - was received.)</li> <li>- May 19 = 323.8 pounds - a loss of 6.2 pounds</li> </ul> <p>Documentation was lacking of the physician having been consistently notified of these significant weight fluctuations, a re-weigh having been done to verify the accuracy of the weight, as well as an assessment as to causative factors for the fluctuations.</p> <p>The Medication Administration Records (MAR) had many entries of R (refused)</p>		<p>by a specialist referral. <b>What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur:</b> All nurses will be in-serviced related to assuring that weights are obtained as ordered. The training also includes assuring that the primary physician is made aware of the results if there is an identified weight fluctuation per facility policy. In addition, the in-service covered assuring that residents that may be declined by specialist be offered the option of being referred to a different specialist. The nurses are responsible for assuring that the resident's physician is notified appropriately of significant changes including weight fluctuations. The nurses are also responsible for assuring that if there is a referral to a specialist that is declined that the resident/family is offered the option of being referred to a different specialist. Please see below for means of monitoring.</p> <p><b>How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put into place:</b> A Performance Improvement Tool has been initiated that will randomly reviews 5 residents related to obtaining of weights and proper physician notification of weights based on any fluctuations per policy. The tool</p>		

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	<p>listed for the dates the weekly weights were to be done. Documentation was also lacking in which the family and/or physician had been notified of the resident's frequent refusals to be weighed.</p> <p>During an interview with RN #1 on 6/25/14 at 8:20 a.m., she indicated that the resident frequently refused to be weighed weekly like she was supposed to be and that it would be marked on the weight record if it was able to be obtained and marked on the MAR with an R if the resident refused.</p> <p>During an interview with LPN #1 on 6/25/14 at 9:45 a.m., she indicated that if a resident refused to allow staff to obtain their weight, especially if a weekly weight, then the resident would re-approached again later that day and every day using different staff and approaches in order to obtain the weight.</p> <p>The LPN also indicated that if weights were significantly different, especially up from previous weight, then an immediate re-weight is obtained and the resident's overall condition would be assessed by nursing to look for causes for the gain with the physician then subsequently being notified of the fluctuation. She indicated that this was especially important if the resident had CHF or</p>		<p>will also review for any specialist referral to determine that if the initial referral was declined that another option was available to the resident/family. The Director of Nursing, or designee, will complete this audit weekly x3, monthly x3, and then quarterly x3. Any issue identified will be immediately corrected. The Quality Assurance Committee will review the tool at the scheduled meeting following the completion of the tool with recommendations as needed based on the outcome of the audit. <b>Date of compliance:</b> 7-16-14</p>				

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	<p>diabetes. She also indicated the resident did refuse frequently to be weighed.</p> <p>A 3/6/14 Care plan titled "The resident has Congestive Heart failure. At risk for fluid volume overload r/t [related to] diagnosis of CHF" included, but were not limited to approaches of: "Weight monitoring weekly. Monitor/document/report to MD PRN [as needed] any s/sx [signs/symptoms] of Congestive Heart Failure: weight gain unrelated to intake."</p> <p>A 5/21/14 Care plan titled "The resident has renal insufficiency r/t Kidney disease" had approaches which included, but were not limited to: "Obtain weights as ordered. Resident/family/caregiver teaching to include the following: Review s/sx that should be reported to medical team such as edema, weight gain, etc."</p> <p>On 5/28/14, the physician gave an order for the resident to be seen by a nephrologist (kidney doctor) due to the resident's diagnosis of chronic kidney disease and increasing BUN (blood, urea and nitrogen) and Creatinine level (chemicals in the body) and gave the specific name of one. A call was made to the nephrologist's office who indicated that the nephrologist refused to see the</p>			

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	<p>resident.</p> <p>During an interview with RN #1 on 6/15/14 at 11:20 a.m., she indicated that she had spoken with the nurse who took the order and made the phone calls to the nephrologist. This nurse had told her that she had notified the resident's primary physician of the nephrologist refusing to care for the resident and that since the physician said "No new orders," she had interpreted that to mean not to pursue finding another nephrologist. RN#1 indicated that the resident nor the family had been asked of they still wanted to pursue the resident being seen by another nephrologist.</p> <p>2. Review of the clinical record for Resident #C on 6/25/14 at noon, indicated the resident was admitted to the facility on 3/12/14 and had diagnoses which included, but were not limited to: hypertension (high blood pressure) and toxic metabolic encephalopathy.</p> <p>3/12/14 Admitting orders indicated weekly weights times 4 weeks were to be done. Upon return from the hospital on 4/24/14, orders again were received for weekly weights until 5/26/14 when a new order for monthly weights was received.</p>				

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	<p>On 6/24/14 at 12:17 p.m., RN #1 presented the resident's Monthly Weight History report and on 6/25/14 at 11:00 a.m., presented the Weight History report from admission to 6/18/14.</p> <p>Review of these histories indicated the following weights:</p> <ul style="list-style-type: none"> <li>- March 13 = 139.4 pounds</li> <li>- March 17 = 138.60 pounds</li> <li>- April 6 = 147.4 pounds - a 8.6 pound gain</li> <li>- April 25 = 156.2 pounds - a 10.8 pound gain</li> <li>- April 28 = 156.2 pounds</li> <li>- May 4 = 153.8 pounds</li> <li>- June 18 = 131 pounds - a loss of 22.8 pounds.</li> </ul> <p>Documentation was lacking of the physician and/or family having been notified of these significant weight fluctuations as well as the difficulty the staff were having in obtaining the weights; a re-weight having been done to verify the accuracy of the weight, as well as an assessment as to causative factors for the fluctuations.</p> <p>During an interview with RN #1 on 6/25/14 at 2:15 p.m., she indicated that the resident had a tendency to be very combative a lot of times and that the CNAs (Certified Nursing Assistants)</p>				

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	<p>were unable to get his weight as ordered but had no documentation of this and was not sure if the staff tried to get the weight at another time. She also indicated that she was not aware of any facility protocol for notifying the physician when there were significant weight fluctuations.</p> <p>A 4/30/14 "Standards Of Care" Nutrition note indicated the resident had experienced zero significant weight gain in the last 30 days.</p> <p>3. Review of the clinical record for Resident #D on 6/24/14 at 12:25 p.m., indicated that the resident had diagnoses which included, but were not limited to: Alzheimer's dementia and hypertension (high blood pressure).</p> <p>On 6/3/10, a physician's order for Monthly weights was received.</p> <p>On 6/24/14 at 12:14 p.m., RN #1 presented the monthly weights between January 2014 and March 2014. Review of these weights at this time indicated the following: - January = 185.2 - February = 188.0 - gain of 2.8 pounds - March = 196.4 - gain of 8.4 pounds</p> <p>Documentation was lacking of the physician and/or family having been</p>			

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	<p>notified of the weight gain.</p> <p>Documentation was also lacking of the resident having been assessed for causative factors for the weight gain as well as a re-weight having been completed to verify the accuracy of the weight.</p> <p>On 6/24/14 at noon, the Administrator presented a copy of the facility's current policy titled "Change in a Resident's Condition or Status". Review of this policy at this time included, but was not limited to: "Our facility shall notify the resident, his or her Attending Physician, and representative 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...e. A significant change in the resident's physical...condition....g. Refusal of treatment...(i.e., two (2) or more consecutive times);...2. Unless otherwise instructed by the resident, the Nurse Supervisor/Charge Nurse will notify the resident's family or representative when:...b. There is a significant change in the resident's physical...status..."</p> <p>On 6/24/14 at 1:00 p.m., RN #1 presented a copy of the facility's current</p>			

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	<p>policy titled "Weekly Weights (SOC) [Standards of Care]". Review of this policy at this time included, but was not limited to: "Standard: Based on a resident's comprehensive assessment, the facility must ensure a resident maintains acceptable parameters of nutritional status, such as body weight...; unless the resident's clinical condition demonstrates that is not possible/ Guidelines:...The Director of Nursing or designee will be responsible for comparing weekly weight to the weight recorded the previous week. Any weight variance of three (3) pounds gain or loss within the past 7 days requires a reweigh within 24 hours. 5. The Director of Nursing or designee will be responsible for notification of the Dietary department, the resident's attending physician, and the resident and/or family member of the weight loss or gain."</p> <p>RN #1 also presented at 1:00 p.m., a copy of the facility's current policy titled "Weekly &amp; Daily weights." Review of this policy at this time included, but was not limited to: "Standard: It will be the facility standard to maintain accurate, timely documentation of weekly and daily weights. These weights will be communicated to the dietitian, dietary manager, and nursing personnel in order to effectively address significant weight</p>			

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	<p>changes and trends. Guidelines:...3. Residents with a variance of +/- 3 pounds from the previous weight will be re-weighed immediately with licensed nurse in attendance for verification of accuracy...5. residents on weekly, daily or other frequent weights will be reviewed at the weekly SOC Committee meetings, with interventions implemented and care plans updated...."</p> <p>This Federal tag is related to Complaint IN00150797.</p> <p>3.1-37(a)</p>				