

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  07/01/2013
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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 a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00128722.</p> <p>Complaint IN00128722 - Unsubstantiated due to lack of evidence.</p> <p>Survey dates: June 24, 25, 26, 27, July 1, 2013</p> <p>Facility number: 000338 Provider number: 155441 AIM number: 100287590</p> <p>Survey Team: Debra Peyton RN,TC Gloria J. Reisert MSW Gwen Pumphrey RN (6/24, 25, 26, 27/13) Nicole Wright, RN Joan Laux, RN (7/1/13)</p> <p>Census bed type: SNF/NF: 33 Total: 33</p> <p>Census payor type: Medicare: 4 Medicaid: 27 Other: 2 Total: 33</p>	F000000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_

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

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	<p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review 7/08/13 by Suzanne Williams, RN</p>				

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F000155 SS=D	<p>483.10(b)(4) RIGHT TO REFUSE; FORMULATE ADVANCE DIRECTIVES The resident has the right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive as specified in paragraph (8) of this section.</p> <p>The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law. Based on observation, interview and record review, the facility failed to provide a resident the right to refuse therapy for 1 of 6 residents reviewed for therapy services. (Resident #18)</p> <p>Findings include:</p> <p>On 6-27-13 at 9:00 a.m., while observing the dining room area outside of the therapy room, COTA (certified occupational therapy assistant) #1 was observed interacting with Resident #18. Resident #18 had his foot on the doorjamb, stated "I don't want to go in there." The COTA #1 asked what he</p>	F000155	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 31, 2013 to the annual licensure survey conducted on June 24, 2013 through July 1, 2013. The facility also requests that our plan of correction be considered for paper review compliance. The facility would be happy to submit any compliance	07/31/2013			

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	<p>wanted. He indicated he already told her, he wanted to go to bed. The COTA #1 replied, "You have to get your therapy done, then you can go to bed." The resident continued to refuse to go into the therapy room, the COTA #1 continued to try to push his wheelchair forward when his foot was on the doorjamb. She asked the resident if he would put his foot back on the foot peg of the wheelchair and he did not. The resident appeared very agitated. He then said, "I don't want to go in there. I am tired." The Administrator was informed of the resident requesting to go to bed and not do therapy and the therapist continued to insist. The Administrator walked over to the therapist and asked if Resident #18 was refusing, the therapist shook her head yes, the Administrator indicated to COTA #1 to let him refuse. The resident was then assisted back to his room. During an interview with Admin, she indicated "When a resident is not being cooperative, you walk away."</p> <p>During an observation on 6-27-13 at 9:21 a.m., Resident #18 was observed in his bed resting.</p> <p>During an observation on 6-27-13 at 10:09 a.m., COTA #1 was observed to be working with another resident in</p>		<p>paperwork needed.</p> <p><b>F155 It is the practice of Corydon Nursing and Rehabilitation Center to assure that resident's rights are honored and that residents may exercise the right to refuse care/services. The correction action taken for those residents found to be affected by the deficient practice include:</b> Residents #18 rights are being honored related to refusing therapy. COTA #1 has been in-serviced related to honoring a resident's rights to refuse therapy <b>Other residents that have the potential to be affected have been identified by:</b> Potentially all residents could be affected. Please see below for measures implemented to prevent reoccurrence. <b>The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:</b> The therapy staff has been in-serviced related to honoring residents' rights to refuse therapy services. Emphasis was given that if a resident refuses therapy that they are allowed to refuse and they may want to approach the resident at a later time to see if the resident will allow their services. If a resident has continued refusal, this will be identified in the plan of care. <b>The corrective action taken to</b></p>				

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	<p>the hallway.</p> <p>During an interview with Administration on 6-27-13 at 2:15 p.m., she indicated she had spoken to numerous residents and none of them indicated to her that they had a bad experience with this therapist. She indicated she spoke to the therapist about the resident's right to refuse therapy.</p> <p>On 7-1-13 at 10:53 a.m., the Administrator indicated that COTA #1 indicated she did not see the resident put his foot on the doorjamb. When informed that COTA #1 was heard requesting the resident remove his foot from the doorjamb and place it back on the foot peg of the wheelchair, the Administrator indicated that COTA #1 just didn't handle the situation right.</p> <p>During record review on 7-1-13 at 11:34 a.m., of Resident #18's chart, there was no charting from nurses or therapists of Resident #18 refusing therapy. No care plans were indicated for refusal of treatments.</p> <p>3.1-4(d)</p>		<p><b>monitor performance to assure compliance through quality assurance is:</b> A Performance Improvement Tool has been initiated that randomly reviews 5 residents to assure that they agree to care/services provided and if they choose to refuse care/services that their right to refuse is honored and that refusals are identified on the plan of care. The Director of Nursing, or designee, will complete this tool weekly x3, monthly x3, then quarterly x3. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations as needed based on the outcomes of the tools. <b>The date the systemic changes will be completed:</b> July 31, 2013</p>		

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F000241 SS=D	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Based on observation, interview and record review, the facility failed to provide care and an environment that maintained a resident's dignity when refusing therapy for 1 of 1 resident randomly observed. (Resident #18)</p> <p>Findings include:</p> <p>On 6-27-13 at 9:00 a.m., while observing the dining room area outside of the therapy room, COTA (certified occupational therapy assistant) #1 was observed interacting with Resident #18. Resident #18 had his foot on the doorjamb, stated "I don't want to go in there." The COTA #1 asked what he wanted. He indicated he already told her, he wanted to go to bed. The COTA #1 replied, "You have to get your therapy done, then you can go to bed." The resident continued to refuse to go into the therapy room, the COTA #1 continued to try to push his wheelchair forward when his foot was on the doorjamb. She asked the resident if he would put his foot back</p>	F000241	<p><b>F241</b></p> <p>It is the practice of this facility to assure that residents' dignity is maintained both during the provision of care/services or if they exercise their right to refuse care/services.</p> <p><i>The correction action taken for those residents found to be affected by the deficient practice include:</i></p> <p>Residents #18 rights are being honored related to refusing therapy. COTA #1 has been in-serviced related to honoring a resident's rights to refuse therapy</p> <p><i>Other residents that have the potential to be affected have been identified by:</i></p> <p>Potentially all residents could be affected. Please see below for measures implemented to prevent reoccurrence.</p> <p><i>The measures or systematic changes that have been put into place to ensure that the deficient</i></p>	07/31/2013			

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	<p>on the foot peg of the wheelchair and he did not. The resident appeared very agitated. He then said, "I don't want to go in there. I am tired." The Administrator was informed of the resident requesting to go to bed and not do therapy and the therapist continued to insist. The Administrator walked over to the therapist and asked if Resident #18 was refusing, the therapist shook her head yes, the Administrator indicated to COTA #1 to let him refuse. The resident was then assisted back to his room. During an interview with Admin, she indicated "When a resident is not being cooperative, you walk away."</p> <p>During an observation on 6-27-13 at 9:21 a.m., Resident #18 was observed in his bed resting.</p> <p>During an observation on 6-27-13 at 10:09 a.m., COTA #1 was observed to be working with another resident in the hallway.</p> <p>During an interview with Administration on 6-27-13 at 2:15 p.m., she indicated she had spoken to numerous residents and none of them indicated to her that they had a bad experience with this therapist. She indicated she spoke to the therapist about the resident's right to</p>		<p><b>practice does not recur include:</b></p> <p>The therapy staff has been in-serviced related to honoring residents' rights to refuse therapy services in a dignified manner. Emphasis was given that if a resident refuses therapy that they are allowed to refuse and they may want to approach the resident at a later time to see if the resident will allow their services. If a resident has continued refusal, this will be identified in the plan of care.</p> <p><b>The corrective action taken to monitor performance to assure compliance through quality assurance is:</b></p> <p>A Performance Improvement Tool has been initiated that randomly reviews 5 residents to assure that their right to refuse care/services is honored in a dignified manner. The Director of Nursing, or designee, will complete this tool weekly x3, monthly x3, then quarterly x3. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations as needed.</p> <p><b>The date the systemic changes will be completed:</b></p> <p>July 31, 2013</p>				

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	<p>refuse therapy.</p> <p>On 7-1-13 at 10:53 a.m., the Administrator indicated that COTA #1 indicated she did not see the resident put his foot on the doorjamb. When informed that COTA #1 was heard requesting the resident remove his foot from the doorjamb and place it back on the foot peg of the wheelchair, the Administrator indicated that COTA #1 just didn't handle the situation right.</p> <p>During record review on 7-1-13 at 11:34 a.m., of Resident #18's chart, there was no charting from nurses or therapists of Resident #18 refusing therapy. No care plans were indicated for refusal of treatments.</p> <p>3.1-3(t)</p>				

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F000250 SS=D	<p>483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE</p> <p>The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Based on record review and interview, the facility failed to provide Social Services assistance related to discharge planning to a resident who was designated as being short term stay according to their Level 2 assessment. This deficient practice affected 1 of 2 residents reviewed for Level 2 Pre-Admission Screening. (Resident #35)</p> <p>Finding includes:</p> <p>Review of the clinical record for Resident #35 on 6/26/13 at 9:54 a.m. indicated the resident was admitted to the facility on 2/22/13 and had diagnoses which included, but were not limited to: explosive personality disorder, senile dementia, and unspecified intellectual difficulties.</p> <p>On 2/5/13, a PASRR [Pre-Admission Screening Resident Review] was completed and the resident was "Determined to have a developmental disability as well as a mental illness. Applicant/Resident has Medical needs: Short term length of = 120</p>	F000250	<p><b>F250</b></p> <p><b>It is the practice of this facility to assure that the all residents receive assistance from Social Services related to any discharge planning.</b></p> <p><b><i>The correction action taken for those residents found to be affected by the deficient practice include:</i></b></p> <p>Resident #35 now has discharge planning in place and documentation related to this process and level II information. Follow-up conversation has occurred with the appropriate agency related to resident being able to remain in the facility.</p> <p><b><i>Other residents that have the potential to be affected have been identified by:</i></b></p> <p>All residents have been reviewed related to their level IIs and any needed discharge planning. Any documentation or interventions needed has been completed.</p> <p><b><i>The measures or systematic changes that have been put into</i></b></p>	07/31/2013			

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	<p>days. NOTE: the NF [Nursing Facility] needs to keep this [name of agency] office informed of [resident's name] progress in order for appropriate discharge planning and level of care procedures to occur regarding her return to her group home setting."</p> <p>Review of the Social Worker notes between 2/15/13 and 6/22/13 failed to locate documentation of having kept them up to date on the resident's progress and her current situation which resulted in a psychiatric hospitalization. Documentation regarding discharge planning per the Level 2 assessment was also lacking.</p> <p>A 4/17/13 QMRP [Qualified Mental Retardation Professional] Review note indicated "Resident is happy with her placement here at Corydon Nursing and Rehabilitation. She was expected to be short term returning to her group home following completion of therapy service, but has decided to stay at the facility where she is closer to her family, showing much progress in mood/behaviors per family."</p> <p>A 4/26/13 Social Service Documentation Tool indicated the resident and family wanted her to stay in the facility for long term care.</p>		<p><b>place to ensure that the deficient practice does not recur include:</b></p> <p>Social Services has been in-serviced related to assuring that discharge planning and documentation occurs related to any planned discharge including those related to level II determinations. Social Services will be responsible for assuring that all documentation and follow through is completed appropriately.</p> <p><b>The corrective action taken to monitor performance to assure compliance through quality assurance is:</b></p> <p>A Performance Improvement Tool has been established that reviews both current and new admissions related to discharge planning including those choosing to discharge or identified to be short term based on the level II. The Administrator, or designee, is responsible for completion of the tool. This tool will be completed weekly x3, monthly x3, then quarterly x3. The quality assurance committee will review the PI tools at the regularly scheduled meetings with additional recommendations if there is any negative outcome on the PI tools.</p> <p><b>The date the systemic changes will be completed:</b></p> <p>July 31, 2013</p>		

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	<p>During an interview with the Social Worker on 6/27/13 at 2:27 p.m., she indicated that on 6/6/13, the facility send a request and physician certification to [the name of the agency] requesting the resident be changed from short term to long term per resident and family request. She indicated that she had been told that the local mental health agency had to come in and do the screening for her to remain LTC [Long Term Care] and that this was what the facility was currently waiting on.</p> <p>When queried if she had followed up with the local mental health agency to see what the current status was and when they would be in to screen the resident, she indicated that she had not. She also indicated she had not made any contact with the agency to keep them up-to-date on how the resident was doing during her stay.</p> <p>The Social Worker also indicated that she was the one responsible for making sure the Level 2's are followed up on.</p> <p>On 6/27/13 at 11:39 a.m., the Business Office Manager presented a copy of the Social Worker's "Job Description" signed on 4/15/13.</p>			

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	<p>Review of this Job Description at this time included, but was not limited to: "General Functions: Assist the Social Services Director/Coordinator in identifying and providing for each resident's social, emotional and psychological needs, and the continuing development of the resident's full potential during his/her stay at the facility and to assist in the planning for his/her discharge...Essential Job Functions: ...Departmental Functions:...Develop a social history, social assessment and care plan which identifies status, pertinent problems and needs, of the resident. Establish realistic goals to be accomplished and the specific action to be taken toward resolution of problems and/or needs of each resident...Document progress notes which relates to each resident's care plan when necessary and within policy time frames. Assist the resident and resident's family in discharge and placement planning..."</p> <p>3.1-34(a)</p>				

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F000279 SS=D	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS 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 record review and interview, the facility failed to develop a care plan for discharge planning for a resident who was designated to be short term only. This deficient practice affected 1 of 30 residents who were reviewed for care plans. (Resident #35)</p> <p>Finding includes:</p> <p>Review of the clinical record for Resident #35 on 6/26/13 at 9:54 a.m. indicated the resident was admitted to the facility on 2/22/13 and had</p>	F000279	<p>F279</p> <p>It is the practice of Corydon Nursing and Rehabilitation Center to assure that care plans are completed in relation to discharge planning.</p> <p><i>The correction action taken for those residents found to be affected by the deficient practice include:</i></p> <p>Resident #35 now has a care plan in place related to discharge planning</p> <p><i>Other residents that have the potential to be affected have been</i></p>	07/31/2013	

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	<p>diagnoses which included, but were not limited to: explosive personality disorder, senile dementia, and unspecified intellectual difficulties.</p> <p>On 2/5/13, a PASRR [Pre-Admission Screening Resident Review] was completed which indicated "Resident determined to have a developmental disability as well as a mental illness. Applicant/Resident has Medical needs: Short term length of = 120 days. NOTE: the NF [Nursing Facility] needs to keep this [name of agency] office informed of [name of resident] progress in order for appropriate discharge planning and level of care procedures to occur regarding her return to her group home setting."</p> <p>Review of the 3/8/13 Admission Minimum Data Set Assessment [MDS] indicated the resident scored a 14/15 on the Brief Interview Mental Status [BIMS], which indicated she was cognitively able to make decisions, and had little energy with no mood or behavior issues.</p> <p>Review of the Quarterly MDS Assessment done in June 2013, indicated the resident scored a 5/15 on the BIMS which indicated she had severe cognitive impairment; she had poor appetite; feeling tired with no</p>		<p><b>identified by:</b></p> <p>All residents have been reviewed related to their level IIs and any needed discharge planning. A care plan has been implemented for those residents requiring discharge planning</p> <p><b>The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:</b></p> <p>Social Services has been in-serviced related to assuring that discharge planning and documentation occurs related to any planned discharge including those related to level II determinations. The in-service also included assuring that there was a care plan in place related to discharge planning. Social Services will be responsible for assuring that all documentation and follow through is completed appropriately.</p> <p><b>The corrective action taken to monitor performance to assure compliance through quality assurance is:</b></p> <p>A Performance Improvement Tool has been initiated that randomly reviews those residents with planned discharge to assure that proper care planning is in place. The tool reviews 5 residents (if</p>				

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	<p>energy; felt bad about herself with feelings of being down and depressed with little interest in things around her. No other mood or behavior issues were noted.</p> <p>Documentation of a care plan regarding discharge planning per the Level 2 assessment was lacking.</p> <p>On 6/27/13 at 11:39 a.m., the Business Office Manager presented a copy of the Social Worker's "Job Description" signed on 4/15/13. Review of this Job Description at this time included, but was not limited to: "...Departmental Functions: Duties:...Develop a...care plan which identified status, pertinent problems and needs, of the resident. Establishes realistic goals to be accomplished and the specific action to be taken toward a resolution of problems and/or needs of each resident...."</p> <p>During an interview with the Social Worker on 6/27/13 at 2:27 p.m., she indicated she had not developed a care plan to address the resident's length of stay.</p> <p>3.1-35(a) 3.1-35(b)(1) 3.1-35(d)(1)</p>		<p>applicable) to assure that if there is discharge planning in place that there is a correlating care plan. The Administrator, or designee, will complete this tool weekly x3, monthly x3, and then quarterly x3. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations as needed if needed based on the outcome of the tools.</p> <p><b>The date the systemic changes will be completed:</b></p> <p>July 31, 2013</p>		

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	3.1-35(d)(2)(A)				

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F000407 SS=D	<p>483.45(b) REHAB SVCS - PHYSICIAN ORDER/QUALIFIED PERSON Specialized rehabilitative services must be provided under the written order of a physician by qualified personnel. Based on interview and record review, the facility failed to ensure a resident received physical therapy as ordered by the physician. This deficient practice affected 1 of 6 residents reviewed for rehabilitative services. (Resident #34)</p> <p>Findings include:</p> <p>Record review on 6/26/13, at 2:23 p.m., for Resident #34, indicated an admission date of 4/3/13 and diagnoses including, but not limited to, pneumonia, urinary tract infection, chronic pain syndrome, osteoarthritis, depression, anxiety, congestive heart failure, history of alcoholism, and history of chronic obstructive pulmonary disease.</p> <p>During an interview on 6/27/13, at 9:50 a.m., the DON (Director of Nurses) indicated Resident #34 was discontinued from physical therapy per PT (physical therapist) #1 on 5/21/13 as he indicated the resident was not appropriate for therapy. She also indicated an order was received from the physician on 5/22/13 to</p>	F000407	<p><b>F407</b></p> <p><b>It is the practice of this facility to assure that all residents receive therapy services as ordered by the attending physician.</b></p> <p><b><i>The correction action taken for those residents found to be affected by the deficient practice include:</i></b></p> <p>Resident #34 is receiving therapy services in accordance with the physician's order.</p> <p><b><i>Other residents that have the potential to be affected have been identified by:</i></b></p> <p>Potentially all residents could be effected. Please see below for systems and means for monitoring.</p> <p><b><i>The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:</i></b></p> <p>The therapy staff has been in-serviced related to providing therapy services in accordance with the physician's orders. The in-service includes provision of</p>	07/31/2013			

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	<p>resume physical therapy. She indicated that PT #1 refused to treat the resident from 5/22/13 through 5/31/13.</p> <p>A review of an order written by PT #1 and dated 5/21/13 indicated to discontinue physical therapy orders and to continue Restorative program for Range of Motion exercises. A physician's order dated 5/22/13 indicated to discontinue the discontinuation order for physical therapy and to start physical therapy 5 times a week for therapeutic exercise and upper and lower body strengthening.</p> <p>A review of the Physical Therapy Log for May 2013, indicated the resident received treatment for only 7 days during the month. There was no indication of treatment, refusal, or illness for dates 5/22/13 through 5/31/13. A review of the PT Daily Treatment Note indicated the resident received therapy from 6/18/13 through 6/20/13, and was discharged from therapy on 6/21/13 due to not wanting to participate.</p> <p>During an interview on 7/1/13, at 10:20 a.m., the DON indicated the physician was not notified of PT #1's refusal to treat Resident #34.</p>		<p>therapy services and physician notification in accordance with the facility policy. The in-service also included notifying the physician if a resident refuses these services in accordance with the facility policy. Please see below for means of monitoring.</p> <p><b>The corrective action taken to monitor performance to assure compliance through quality assurance is:</b></p> <p>A Performance Improvement tool has been established that randomly reviews 5 residents with therapy orders to assure that therapy is being provided in accordance with the physician's order. It also reviews for resident refusals and physician notification. The Director of Nursing, or designee, will complete the tool weekly x3, monthly x3, then quarterly x3. Any issues identified will be immediately addressed. 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 outcomes of the tool.</p> <p><b>The date the systemic changes will be completed:</b></p> <p>July 31, 2013</p>				

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	<p>A review of a policy titled "Change in a Resident's Condition or Status" presented by the DON, dated 4/2012 and identified as their current policy, included but was not limited to, "The Nurse Supervisor/Charge Nurse will notify the resident's Attending Physician or On-Call Physician when there has been refusal of treatment...2 or more consecutive times."</p> <p>3.1-23(b)</p>				

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F000431 SS=D	<p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS &amp; BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on observation, interview and record review, the facility failed to ensure medications were properly stored and/or labeled. This deficient</p>	F000431	<p>F431</p> <p>It is the practice of this facility to assure that all medications are</p>	07/31/2013			

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	<p>practice affected 2 of 2 medication carts, 1 medication storage room, and 3 of 33 residents reviewed for medication storage. (Residents #31,7,38).</p> <p>Findings include:</p> <p>Review of the medication cart for the back hall on 6/26/13 at 10:27 a.m., indicated a medication labeled Hydrocortisone Topical Cream 0.5% was in the top drawer with improper labeling. The medication was observed without a resident's name or physician direction. When asked, RN #1 indicated the medication belonged to Resident #31. RN#1 indicated medications usually have a label from the pharmacy displaying the resident's name clearly with physician direction.</p> <p>Review of the front medication cart on 6/26/13 at 10:15 a.m., indicated one bottle of TUMS was without proper labeling. The marking on the cap was "EB". When asked RN#1 indicated the medication belonged to Resident #7. RN#1 removed the medication from the medication cart.</p> <p>During an observation of the medication storage room on 6/26/13 at 10:20 a.m., a 2 mg vial of</p>		<p><b>labeled and stored properly.</b></p> <p><i>The correction action taken for those residents found to be affected by the deficient practice include:</i></p> <p>Residents' #7 and #31 medications are now labeled and stored properly. Resident #38 no longer resides in the facility.</p> <p><i>Other residents that have the potential to be affected have been identified by:</i></p> <p>All residents medications have been reviewed to assure that they are labeled and being stored properly.</p> <p><i>The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:</i></p> <p>The nurses have been in-serviced related to assure that all medications are labeled and stored appropriately. The in-service included what the label must contain and how medications are to be stored properly.</p> <p><i>The corrective action taken to monitor performance to assure compliance through quality assurance is:</i></p> <p>A Performance Improvement Tool has been initiated that randomly reviews 5 residents medication</p>				

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	<p>lorazepam was open on the counter. The vial was observed to be half full of medication. RN#1 indicated the medication belonged to Resident #38. RN#1 indicated the night shift nurse probably forgot to waste the medication with the day shift nurse.</p> <p>The medication storage room was also observed to have a storage bag of 7 individual packets of Juven (nutritional supplement). The storage bag had no label to indicate who the medication belonged to. When asked RN#1 was unable to identify whose medication it belonged to.</p> <p>Review of the policy and procedure titled "Medication Storage in the Facility" received from the DON on 6/26/13 at 10:35 a.m. indicated medications are to be properly labeled with information not limited to resident name and physician order. The policy also indicated controlled medications should be stored under a double lock system.</p> <p>3.1-25(j)</p>		<p>labeling and storage. The Director of Nursing, or designee, will complete these tools weekly x3, monthly x3, then quarterly x3. Any issues identified will be immediately corrected and additional training will immediately occur. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations for new interventions as needed based on the outcomes of the tools.</p> <p><b>The date the systemic changes will be completed:</b></p> <p>July 31, 2013</p>		

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F000465 SS=D	<p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation, interview and record review, the facility failed to provide a clean and safe interior for 2 of 33 residents in 1 of 18 rooms reviewed for environment. (Room #11)</p> <p>Findings include:</p> <p>On 6-27-13 at 3:10p.m., the following was observed in room 11. The marble-like window sill was observed to be broken in 4 pieces, easily moved up and down and unattached to the wood underneath. The window sill was observed to be held in place with plastic tape. The wall behind bed A is observed to have a patched area 2.5ft x 1ft in size that is movable. When touched it moves in and out and is very soft. The wall is also very soft and movable around the air conditioning unit that is on the same wall as the patched area. The wall behind bed B is observed to have two 1in x 1in holes and the wall is also very soft and movable.</p> <p>During an interview with the Maintenance Director on 6-27-13 at</p>	F000465	<p><b>F465</b></p> <p>It is the practice of this facility to assure that residents are provided a clean and safe interior.</p> <p><b>The correction action taken for those residents found to be affected by the deficient practice include:</b></p> <p>Room #11 has been reviewed and appropriate repairs made. The broken window and window seal have been corrected. The Patched area has been repaired. The wall around the air conditioning has also been repaired. The holes behind bed B have been repaired.</p> <p><b>Other residents that have the potential to be affected have been identified by:</b></p> <p>All resident rooms have been reviewed to assure that any repairs needed are completed.</p> <p><b>The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:</b></p> <p>The Maintenance Director has been</p>	07/31/2013

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	<p>3:30p.m indicated that he was unaware of the window sill being broken and held in place with tape. He indicated he would fix it immediately. He indicated no one had put in a work request for it. When showed the wall behind the two beds, he indicated that this room was the next room to be remodeled and the wall would be addressed. He indicated there was not a time frame for that remodel as of yet. He indicated the facility had to make arrangements to place the residents in different rooms temporarily and there are no rooms available to do that. When asked if he keeps any kind of log indicating his scheduled maintenance or activities throughout a specific time frame, he indicated he does not keep any kind of log like that. He indicated he can be in 15 different places in a day.</p> <p>On 6-27-13 at 3:45p.m., review of the maintenance slips provided by the Maintenance Director do not indicate a need for repairs in Room 11.</p> <p>3.1-19(f)</p>		<p>in-serviced related making rounds and identifying any potential issues in residents' rooms that need repaired. All facility staff has been in-serviced related to assuring that if they identify an area in the building that is in need of repair that a Work Request be filled out properly so that the needed repair is communicated appropriately to the maintenance department.</p> <p><b>The corrective action taken to monitor performance to assure compliance through quality assurance is:</b></p> <p>A Performance Improvement Tool has been initiated that randomly reviews 5 resident rooms/areas to assure that they are clean and safe. The Administrator, or designee, will complete these tools weekly x3, monthly x3, then quarterly x3. Any issues identified will be immediately communicated with the Maintenance Director for repair. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations for new interventions as needed based on the outcomes of the tools.</p> <p><b>The date the systemic changes will be completed:</b></p> <p>July 31, 2013</p>				

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F009999	<p>State Findings:</p> <p>1. The facility shall have a personnel policy that considers references and any convictions in accordance with IC 16-28-13-3.</p> <p>This State Rule was not met as evidenced by:</p> <p>Based on record review and interview, the facility failed to ensure reference checks were completed for all employees prior to hire. This deficient practice affected 4 of 6 employee records reviewed. (LPN #1, CNA #2, CNA #3, and CNA #4) [Certified Nursing Assistant]</p> <p>Findings included:</p> <p>Review of the Employee Records on 7/1/13 at 2:20 p.m. indicated the following employees were missing Reference checks:</p> <p>A. LPN #1 was hired into the nursing department on 4/3/13. No reference checks had been completed.</p> <p>B. CNA #2 was hired into the nursing department on 5/19/13. No reference</p>	F009999	<p><b>F9999</b></p> <p><b>It is the practice of this facility to assure that reference checks are completed on all potential employees prior to the hiring process.</b></p> <p><b>The correction action taken for those residents found to be affected by the deficient practice include:</b></p> <p>Employees LPN #1, CNA #2, CNA #3, and CNA #4, have had references checks completed and placed in their file.</p> <p><b>Other residents that have the potential to be affected have been identified by:</b></p> <p>All employees file be reviewed to assure that all employees have documentation of reference checks in accordance with the facility policy.</p> <p><b>The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:</b></p> <p>All department heads have been in-serviced related to assuring that when they hire potential new employees that reference checks be completed prior to actually hiring.</p>	07/31/2013			

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	<p>checks had been completed.</p> <p>C. CNA #3 was hired into the nursing department on 4/1/13. No reference checks had been completed.</p> <p>D. CNA #4 was hired into the nursing department on 4/3/13. No reference checks had been completed.</p> <p>During an interview with the Business Office Manager on 7/1/13 at 2:25 p.m., she indicated that several employees did not have reference checks completed and was unable to account as to why.</p> <p>Review of the Personnel File Audit Tool presented by the Business Office Manager on 7/1/13 at 2:25 p.m. indicated "Orientation Checklist " went under the "Training/Education (Red Section)" of the employee file.</p> <p>3.1-14(a)</p> <p>2. Each facility shall maintain current and accurate personnel records for all employees. The personnel records for all employees shall include: documentation of orientation to the facility and to the specific job skills.</p>		<p>As a second review, the business office manager will review all personnel files to assure that reference checks are present prior to filing their employment record</p> <p><b>The corrective action taken to monitor performance to assure compliance through quality assurance is:</b></p> <p>A Performance Improvement Tool has been initiated that randomly reviews 5 current employee files to assure that they contain reference checks in accordance with the regulation. The Administrator, or designee, will complete these tools weekly x3, monthly x3, then quarterly x3. Any issues identified will be immediately corrected and additional training will immediately occur. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations for new interventions as needed based on the outcomes of the tools.</p> <p><b>The date the systemic changes will be completed:</b></p> <p>July 31, 2013</p> <p>F9999</p> <p><b>It is the practice of this facility to assure that employees receive job</b></p>		

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	<p>This State Rule was not met as evidenced by:</p> <p>Based on record review and interview, the facility failed to ensure employees had received orientation to their specific job duties. This deficient practice affected 3 of 6 employee files reviewed. (CNA #2, CNA #4, and Dietary Manager) [Certified Nursing Assistant]</p> <p>Findings include:</p> <p>Review of the Employee Personnel files on 7/1/13 at 2:22 p.m., indicated the following employees failed to receive orientation to their specific job duties before starting their job:</p> <p>A. CNA #2 was hired into the nursing department on 5/19/13. Documentation was lacking of job specific orientation.</p> <p>B. CNA #4 was hired into the nursing department on 4/3/13. Documentation was lacking of job specific orientation.</p> <p>C. The Dietary Manager was hired on 5/23/13. Documentation was lacking of job specific orientation.</p> <p>During an interview with the Business Office Manager on 7/1/13 at 2:25</p>		<p><b>specific orientations.</b></p> <p><b><i>The correction action taken for those residents found to be affected by the deficient practice include:</i></b></p> <p>CNA #2, CNA #4, and the Dietary Manager now have job specific orientations in place.</p> <p><b><i>Other residents that have the potential to be affected have been identified by:</i></b></p> <p>All current employee files have been reviewed to assure that there are job specific orientations in place.</p> <p><b><i>The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:</i></b></p> <p>All department heads have been in-serviced related to assuring that when they hire potential new employees that job specific orientations be completed as part of the orientation process. As a second review, the business office manager will review all personnel files to assure that job specific orientations are present prior to filing their employment record</p> <p><b><i>The corrective action taken to monitor performance to assure compliance through quality</i></b></p>		

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	<p>p.m., she indicated that several employees did not have a check of their references completed prior to hire and was unable to account as to why.</p> <p>Review of the Personnel File Audit Tool presented by the Business Office Manager on 7/1/13 at 2:25 p.m. indicated "Orientation Checklist " went under the "Training/Education (Red Section)" of the employee file.</p> <p>3.1-14(q)(7)</p> <p>3. A physical examination shall be required for each employee of a facility within one (1) month prior to employment. The examination shall include a tuberculin skin test, using the Mantoux method ( 5 TU PPD), administered by persons having documentation of training from a department-approved course of instruction in intradermal tuberculin skin testing, reading, and recording unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The tuberculin skin test must be read prior to the employees starting work. The facility must assure the following: (1)</p>		<p><b>assurance is:</b></p> <p>A Performance Improvement Tool has been initiated that randomly reviews 5 current employee records to assure that they all include job specific orientations. The Administrator, or designee, will complete these tools weekly x3, monthly x3, then quarterly x3. Any issues identified will be immediately corrected and additional training will immediately occur. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations for new interventions as needed based on the outcomes of the tools.</p> <p><b>The date the systemic changes will be completed:</b></p> <p>July 31, 2013</p> <p>F9999</p> <p>It is the practice of this facility to assure that employees receive a tuberculin skin test that is read prior to resident contact and that a second step tuberculin skin test is administered after the first one is negative.</p> <p><b>The correction action taken for those residents found to be affected by the deficient practice include:</b></p>		

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	<p>At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. For health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first-step is negative, a second step should be performed one (1) to three (3) weeks after the first step.</p> <p>This State rule was not met as evidenced by:</p> <p>Based on record review and interview, the facility failed to ensure first-step tuberculin skin tests were administered and read prior to the start of resident contact and failed to administer a second-step skin test after the first-step was negative. This deficient practice affected 3 of 6 employee files reviewed. (CNA #2, CNA #3, CNA #4 and CNA #5) [Certified Nursing Assistant]</p> <p>Findings included:</p> <p>Review of the Employee personnel files on 7/1/13 at 2:20 p.m., indicated</p>		<p>CNA #2, #3, #4, and #5 have documentation of 2-step tuberculin skin testing.</p> <p><b>Other residents that have the potential to be affected have been identified by:</b></p> <p>All employee files that have been hired in the last year have been reviewed to assure that all employees have a documented appropriate tuberculin skin testing. The system has been changed to assure that the initial tuberculin skin testing is read for any new hires prior to any contact with the residents. Please see below.</p> <p><b>The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:</b></p> <p>All Department Directors have been in-serviced related to the facility policy for tuberculin skin testing. The in-service included that an employee is not allowed to have any contact with residents unless the first step tuberculin skin test has been read and negative. A second review will occur in the business office to assure that the skin test was read and that the record is not filed until the entire 2-step process is completed.</p> <p><b>The corrective action taken to monitor performance to assure</b></p>				

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	<p>the following employees had their first step tuberculin skin testing given on the day of employment and had resident contact prior to it being read and failed to administer a second-step tuberculin skin test after the first-step was negative.</p> <p>A. CNA #2 was hired into the nursing department on 5/19/13 and began having resident contact through her duties. Her first-step was administered on 5/19/13 - date of hire - and read on 5/22/13. Documentation was lacking of a second-step TB having been administered.</p> <p>B. CNA #5 was hired into the nursing department on 4/30/13 and had resident contact through her duties. Her first step was administered on 4/29/13 and read on 5/2/13.</p> <p>C. CNA #4 was hired into the nursing department on 4/3/13 and had resident contact through her job duties. Her first-step TB test was administered on 4/3/13 - date of hire - and was read on 4/6/13.</p> <p>During an interview with the Business Office Manager on 7/1/13 at 2:25 p.m., she indicated TB tests were given upon hire.</p>		<p><b>compliance through quality assurance is:</b></p> <p>A Performance Improvement Tool has been initiated that randomly reviews 5 employees to assure that they did not start position until initial tuberculin skin test read and negative and that the 2-step process has been completed. The Administrator, or designee, will complete these tools weekly x3, monthly x3, then quarterly x3. Any issues identified will be immediately corrected and additional training will immediately occur. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations for new interventions as needed based on the outcomes of the tools.</p> <p><b>The date the systemic changes will be completed:</b></p> <p>July 31, 2013</p>		

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	<p>On 7/1/13 at 3:30 p.m., the Director of Nursing presented a copy of the facility's current policy titled "Tuberculosis, Screening Employees For". Review of this policy at this time included, but was not limited to:</p> <p>"Policy Statement: This facility shall screen all employees for tuberculosis infection and disease (TB)...Screening New Employees:...A physical examination shall be required for each employee of a facility within one (1) month prior to employment. The examination shall include a tuberculin skin test, using the Mantoux method ( 5 TU PPD), administered by persons having documentation of training from a department-approved course of instruction in intradermal tuberculin skin testing, reading, and recording unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The tuberculin skin test must be read prior to the employees starting work. The facility must assure the following: (1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. For health care workers</p>			
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	<p>who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first-step is negative, a second step should be performed one (1) to three (3) weeks after the first step."</p> <p>3.1-14(t)(1)</p>			