

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155029	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/26/2013
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NAME OF PROVIDER OR SUPPLIER COMMUNITY NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 5600 E 16TH ST INDIANAPOLIS, IN 46218
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F000000	<p>This visit was for Investigation of Complaint IN00129768.</p> <p>Complaint IN00129768 - Substantiated. Federal/state deficiency related to the allegations is cited at F309.</p> <p>Survey dates: June 25, 26, 2013</p> <p>Facility number: 000012 Provider number: 155029 AIM number: 100274900</p> <p>Survey team: Chuck Stevenson RN</p> <p>Census bed type: SNF/NF: 94 Total: 94</p> <p>Census payor type: Medicare: 13 Medicaid: 67 Other: 14 Total: 94</p> <p>Sample: 3</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review 7/01/13 by Suzanne</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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	Williams, RN			

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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 interview, the facility failed to ensure assessments were completed and health care plans were developed and implemented for a newly admitted resident (Resident B) with a colostomy and a dialysis fistula, for 1 resident of 3 reviewed for assessments and care plans in a sample of 3.</p> <p>Findings include:</p> <p>1. The record of Resident B was reviewed on 6/25/13 at 10:00 a.m.</p> <p>Diagnoses included, but were not limited to, renal insufficiency, chronic kidney disease, diabetes mellitus, chronic total occlusion of coronary artery, epilepsy with recurrent seizures, acute cerebrovascular disease, peripheral vascular disease, and left tibia fracture.</p> <p>Resident B's record indicated she was admitted to the facility on 5/17/13</p>	F000309	<p>The creation and submission of the plan of correction does not constitute an admission by this Provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 plan of correction be considered the letter of credible allegation and requests a Desk Review in lieu of a Post Survey Revisit on or after July 26, 2013.</p> <p>F309 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident no longer resides in this facility. Staff education on admission assessments and care plans</p>	07/26/2013			

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	<p>for rehabilitation following a hospital stay for treatment of a fractured left tibia which she experienced from a fall at home. The goal was for the resident to return home following rehabilitation.</p> <p>A hospital "Imaging Results" report dated 5/15/13 indicated "Indication for study: Patient with a left arm fistula (a surgically created venous access used for kidney dialysis)...suspect stenosis (narrowing)...."</p> <p>A facility progress note dated 5/18/13 at 12:38 a.m., noted to be the first progress note following Resident B's admission to the facility, indicated in it's entirety:</p> <p>"Resident is Ax3 (alert to person, place, and time) speech is clear and understandable. No natural teeth present. Vision is impaired. Lungs are clear of crackles and wheezing. Bowel sounds are present in all four quadrants. Colosomy [sic] (colostomy) on lower left quadrant. Fistual (sic; fistula) left anticubidal [sic] (anticubital, the area of the inner arm in front of the elbow) area. Discoloration present on right forearm. Cast on lower left leg due to fracture of tibia. Resident states that she is not currently in any pain. Will</p>		<p>for staff caring for resident B. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? Any resident who admits to this facility has the potential to be affected by this alleged deficient practice. An audit was conducted on any resident who admitted within the last thirty (30) days to ensure assessments were completed and care plans were developed. Any discrepancies were corrected at that time. There will be corrective action for all deficiencies up to and including termination. Staff education on Admission assessments and care plans will be done by 07/26/2013 by the Director of Nursing Services and/or designee What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur? Staff education on Admission assessments and care plans will be done by 07/26/2013 by the Director of Nursing Services and/or designee. Review of all new admission documentation, assessments, and care plans will be reviewed the following morning during to ensure completeness</p>				

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	<p>continue to monitor for changes. Call light within reach."</p> <p>A nurse's progress note dated 8/18/13 at 3:00 p.m. indicated "...F/U (follow up) d/t (due to) fall this AM...Fistula + (positive for) bruit/thrill" (bruit is a sound, and thrill is a vibration, that blood makes passing through the fistula. Both are used to assess the functionality of the fistula).</p> <p>Resident B's record was reviewed in its entirety. There was no documentation of any assessment of the resident's colostomy site or characteristics of the stool. The record contained no documentation of any assessment of the fistula other than the above noted progress note of 8/18/13. The record contained no health care plans for the fistula or the colostomy.</p> <p>During an interview on 6/25/13 at 1:30 p.m. with the Administrator and Director of Nursing (D.O.N.), the D.O.N. indicated Resident B did have a colostomy and fistula on admission to the facility. She indicated that Resident B's record did not contain either an initial or ongoing assessments of either the colostomy or the fistula, and that there were no care plans for the fistula or the</p>		<p>clinical meeting by the Unit Manager, Assistant Director of Nursing, and Director of Nursing How will the corrective action be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <p>Admission/Readmission CQI will be utilized weekly X4 then monthly thereafter for atleast 6 months. Results of the audits will be submitted to the CQI Committee for review and follow up. Action plan will be developed for compliance < 90%. Corrective action up to and including termination for issues identified. Compliance date: 07/26/2013</p>				

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	<p>colostomy.</p> <p>During an interview on 6/15/13 at 2:05 p.m., the D.O.N. indicated it was the admitting nurse's responsibility to complete a full assessment of incoming residents, and to develop and implement interim care plans that identified the resident's care needs, and that in the case of Resident B's colostomy and fistula, the admitting nurse had not documented completing these tasks.</p> <p>During an interview with the D.O.N. on 6/26/13 at 11:45 a.m. with the Administrator present, the D.O.N. indicated assessment of Resident B's colostomy should have included, at a minimum, color and condition of the skin, supplies used and needed, frequency and consistency of stool, and any changes. She indicated this assessment should have been initiated on admission and completed every shift and additionally as needed. She indicated Resident B's fistula should have been assessed at admission and every shift, with skin condition and bruit and thrill checked and documented. She also indicated interim care plans should have been developed to meet these care needs.</p> <p>A facility policy titled "Dialysis Care"</p>						

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	<p>dated 9/2012, received from the Administrator on 6/26/13 at 1:15 p.m., indicated:</p> <p>"Policy: It is the policy of (name of the facility's parent company) to ensure that the resident is rendered necessary services for the provision and maintenance of dialysis services...</p> <p>Procedure: Dialysis residents will be assessed at admission to include dialysis site, bruit and thrill, drainage, condition of skin, and vital signs...</p> <p>An assessment of the resident's dialysis site will be completed daily to include bruit and thrill (if applicable), condition of skin at site, drainage, pain warmth, redness and recorded on the Medication Administration Record...</p> <p>All specific resident care areas will be addressed on the plan of care."</p> <p>A facility policy titled "Nursing Admission/Return Admission Procedure" dated 9/2012, received from the Administrator on 6/26/13 at 10:45 a.m., indicated:</p> <p>"Purpose: To provide baseline and accurate documentation of the mental</p>						

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	<p>and physical condition of each resident admitted or readmitted to the facility...Admission procedures will be followed for all new admissions including respite care.</p> <p>Nursing assessment/documentation at admission:...All resident will be assessed at least every shift for the first 72 hours following admission. Documentation will be related to pertinent health conditions, including vital signs, pain symptoms...The admitting nurse must review the pre-admission assessment, history and physical, hospital discharge summary...A thorough head to toe assessment (including skin) must be done at admission. Any alterations in skin integrity i.e. pressure sores, vascular wounds, and surgical wounds, must be identified on nursing assessment and documented on individual wound evaluation reports..."</p> <p>After completion of the initial nursing assessment, the interim care plan must be initiated...All pertinent resident health care issues must be addressed in the interim care plan..."</p> <p>This federal tag relates to Complaint IN00129768.</p> <p>3.1-37(a)</p>				

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