

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155486	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/24/2014
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NAME OF PROVIDER OR SUPPLIER MIDDLETOWN NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 131 S 10TH ST MIDDLETOWN, IN 47356
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Dates of Survey: September 18, 19, 22, 23, and 24, 2014</p> <p>Facility number: 000343 Provider number: 155486 AIM number: 100289600</p> <p>Survey team: Diana Sidell RN, TC Leslie Parrett RN Barbara Gray RN Angel Tomlinson RN</p> <p>Census bed type: SNF/NF: 27 Total: 27</p> <p>Census payor type: Medicare: 3 Medicaid: 19 Other: 5 Total: 27</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed on September</p>	F000000	<p>This plan of correction is submitted to serve as a Credible Allegation of compliance in association with stated completion dates. Preparation and/or execution of this plan of correction does not constitute an admission of agreement by the provider of the conclusion on the statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by State and Federal laws.</p>	
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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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F000272 SS=D	<p>29, 2014 by Cheryl Fielden, RN.</p> <p>483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.</p> <p>A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Contenance; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.</p> <p>Based on observation, interview and</p>	F000272	WHAT CORRECTIVE ACTION(S) WILL BE ACCOMPLISHED FOR THOSE	10/24/2014
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	<p>record review, the facility failed to correctly code a resident's Minimum Data Set (MDS) assessments, for 1 of 19 residents reviewed for MDS assessments. (Resident #23)</p> <p>Findings include:</p> <p>On 9/18/14 at 11:13 a.m., RN #1 indicated Resident #23 had a right hand contracture.</p> <p>On 9/22/14 at 9:29 a.m., Resident #23 was observed seated upright in her bed. On Resident #23's right hand her fingers were turned in toward her palm with the 2 middle fingers almost touching her palm. Resident #23 indicated she could not extend her fingers out on her right hand.</p> <p>On 9/22/14 at 11:43 a.m., Resident #23 was observed in the therapy room with 3 electrodes attached to her right arm that were connected to a (name of nerve stimulation) machine. At that time, Occupational Therapist #3 indicated Resident #23 was receiving right hand contracture management.</p> <p>Resident #23's record was reviewed, on 9/22/14 at 1:37 p.m. Her diagnosis included but was not limited to Alzheimer's Dementia.</p>		<p>RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE. Resident #23's has been receiving treatment for her contracture Resident 23's MDS has been updated to include the contracture in the functional limitation range of motion section. HOW OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE WILL BE IDENTIFIED AND WHAT CORRECTIVE ACTION(S) WILL BE TAKEN. Any resident with a contracture could be affected. The MDS's of all residents with a contracture has been updated to assure the accurate coding for the contracture. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR. All nursing personnel were re-educated on 10-8-14 regarding contractures and how to manage those contractures. An audit tool (see attachment #1) has been developed to assist the DON in assuring that all residents with contractures will have it documented on their individual MDS. HOW THE CORRECTIVE ACTION(S) WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR, I.E; WHAT QUALITY ASSURANCE PROGRAM WILL BE PUT INTO</p>				

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F000282 SS=D	<p>Her most recent quarterly Minimum Data Set (MDS) assessment dated 7/2/14, indicated she was usually understood and was usually able to understand others. She scored 12 on her Brief Interview for Mental Status (BIMS) exam indicating she was moderately impaired for her daily decision making skills.</p> <p>Her last 3 quarterly MDS assessments dated 1/25/14, 4/16/14, and 7/2/14, indicated she had no functional limitation in her range of motion.</p> <p>On 9/24/14 at 1:57 p.m., the MDS Coordinator indicated Resident #23 had a right hand contracture. She indicated she had coded the MDS's dated 1/25/14, 4/16/14, and 7/2/14, incorrectly for contractures. She indicated the contractures should have been coded in the functional limitation range of motion section of her MDS's.</p> <p>3.1-31(a)</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</p>		<p>PLACE. The results of the audit tool for contractures will be discussed during the quarterly Quality Assurance meeting with the Medical Director and the IDT team. The audit tool will be used one time monthly for the first 6 months to assure compliance. After that time, with 100% compliance for at least 6 months, the Quality Assurance committee will recommend either further monitoring or to cease using the monitoring tool. Ongoing monitoring will continue by the MDS coordinator to assure compliance. Respectfully requesting paper compliance for F 272.</p>				

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	<p>persons in accordance with each resident's written plan of care.</p> <p>A. Based on interview and record review, the facility failed to follow residents' fall care plans, in that one resident failed to have both wheelchair foot rests under the resident's feet during transport (Resident #8), and one resident was not transferred with assist of 2 and the resident had to be sat on the floor when the breaks of the wheelchair did not lock (Resident #43). This affected 2 of 19 residents reviewed for care plans.</p> <p>B. Based on interview and record review the facility failed to obtain a physician's order to establish a code status for a resident who was admitted to the facility on 5/7/14 and passed away on 5/9/14 for 1 of 1 resident's reviewed for death in a total sample of 19. (Resident #25).</p> <p>Findings include:</p> <p>A. 1. On 9/18/14 at 11:33 a.m., RN #1 indicated Resident #8 had fell in her bedroom on 8/26/14.</p> <p>Resident #8's record was reviewed on 9/23/14 at 10:16 a.m. Diagnoses included but were not limited to Alzheimer's dementia and osteoporosis.</p>	F000282	<p>WHAT CORRECTIVE ACTION(S) WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE. A. 1. All nursing personnel have been re-educated regarding the need to keep the footrests under her feet regardless of the distance she is being pushed due to her propensity to lean forward and possibly fall. She was seen by therapy and currently has a "busy apron" to assist in preventing her from leaning too far forward. In addition to that, a wheelchair has been ordered based on the recommendations from therapy to better deal with her leaning. A. 2. All nursing personnel have been re-educated regarding the requirement to follow the assignment sheets of each resident and to have 2 people transfer Resident #43. B. Resident #25 expired on May 9, 2014. The discharge papers from the hospital did indicate that she made the decision to not have CPR performed due to her ongoing heart condition. As stated, she was unable to tell us her wishes upon admission and the next day. From this point on, the ADON will obtain a physician's order the day of admission. All residents are a full code unless they have a physicians order or living will to</p>	10/24/2014

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	<p>Resident #8's admission Minimum Data Set (MDS) assessment dated 7/14/14, indicated she was sometimes understood and she usually understood others. She scored 5 on her Brief Interview for Mental Status (BIMS) exam, indicating she was severely impaired for her daily decision making skills. She was totally dependent on 2 plus persons for transfers. She was totally dependent on 1 person for bed mobility, dressing, toileting and personal hygiene. She did not walk in her bedroom.</p> <p>Resident #8's fall plan of care initiated 7/14/14, indicated she had the potential for falls due to a history of falls and a diagnosis of Alzheimer's disease. Resident #8's goal indicated she would remain free of falls through her next review. Resident #8's interventions included but were not limited to, transferring her with 1 to 2 staff members at all times and a personal alarm. An intervention added to her fall plan of care on 7/18/14, indicated her wheelchair foot rests would be pushed out to the side of her wheelchair unless staff were pushing her.</p> <p>A nurse's note for Resident #8 dated 8/26/14 at 8:10 p.m., indicated the nurse was called to the resident's room by a CNA. The resident was lying on the</p>		<p>the contrary. CPR will be initiated based on American Red Cross guidelines. HOW OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE WILL BE IDENTIFIED AND WHAT CORRECTIVE ACTION(S) WILL BE TAKEN. A. 1. All residents who are at risk for falls could be affected. All nursing personnel have been re-educated regarding the need to keep the footrests under her feet regardless of the distance she is being pushed due to her propensity to lean forward and possibly fall. Resident 8 also has a "busy apron" to assist in preventing her falls and a new wheelchair has been ordered for her based on recommendations from therapy which should also help keep her from falling. A. 2. All residents who are at risk for falls could be affected. All nursing personnel have been re-educated regarding the requirement to follow the assignment sheets of each resident and to have 2 people transfer Resident #43. B. All residents could be affected. The ADON has gone through all charts to assure that we have updated code status's on each resident. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR.</p>		

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	<p>floor on her left side in a fetal position between her bed and dresser. The CNA reported to the nurse Resident #8 had fell out of her wheelchair hitting her head. Resident #8 had a purplish raised area on her left side above her eye. No other injuries were observed. Resident #8 was assisted to bed and received perineal care related to being incontinent.</p> <p>A nurse's note for Resident #8 dated 8/26/14 at 8:30 p.m., indicated she was transported to a nearby hospital for assessment and treatment.</p> <p>An interview with CNA #6 on 9/23/14 at 3:11 p.m., indicated on 8/26/14, she pushed Resident #8 from her bathroom to her bed. She indicated Resident #8's wheelchair foot rests were left swung out to the sides of the wheelchair when she pushed her from the bathroom to her bed. She indicated she would place the wheelchair foot rests under Resident #8's feet if she were pushing her for a long distance but not necessarily from her bathroom to her bed. She indicated Resident #8 continued to lean forward in her wheelchair a lot.</p> <p>A. 2. Resident #43's record was reviewed on 9/22/14 at 1:20 p.m. Physician's admission orders, dated 8/18/2014, indicated Resident #43 was admitted with diagnoses that included,</p>		<p>A. 1. All C.N.A assignment sheets for each resident have been updated and are being checked weekly (see Attachment #2) to assure the information contained is accurate. A. 2. All C.N.A assignment sheets for each resident have been updated and are being checked weekly to assure the information contained is accurate. In addition to this, random checks are being performed by the DON or her designee to watch transfers (Attachment #3) to assure that staff are being compliant and following directions as stated on the assignment sheets. B. The ADON will monitor all new admissions for code status orders (Attachment #4) and obtain those orders upon admission for all new residents. HOW THE CORRECTIVE ACTION(S) WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR, I.E; WHAT QUALITY ASSURANCE PROGRAM WILL BE PUT INTO PLACE. A. 1. The results of the checklist for the assignment sheets will be discussed during the quarterly Quality Assurance meeting with the Medical Director and the IDT team. The checklist will continue being monitored weekly for one month. If no further issues, then the assignment sheets will be audited on a monthly basis. Once 100% accuracy has been obtained and held for three months, whether to</p>				

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	<p>but were not limited to, chronic low blood pressure, end stage renal disease, fractured left ankle, polycystic kidney disease, diverticulosis, and a right, below the knee amputation. The Physician's orders also indicated "Activity level: Transfer to w/c [with] 2."</p> <p>A "Fall Risk Assessment", dated 8/18/14, indicated a total score of 14, where a score above 10 represents a high risk for falls.</p> <p>An admission Minimum Data Set (MDS) assessment dated 8/27/14, indicated Resident #43 was cognitively intact, required extensive assist of two for transfers, did not ambulate, used a wheelchair for locomotion, balance was not steady, was only able to stabilize with staff assistance moving from a seated to a standing position and during surface to surface transfer (transfer between bed and chair or wheelchair), and had limitation in range of motion with impairment on one side of lower extremity (hip, knee, ankle, foot).</p> <p>A care plan, with a start date of 8/27/14, indicated: "Problem: Resident has potential for falls D/T (due to) fall history. Goal: [Resident #43] will remain free of falls qd (every day) thru next review. Approach: 1. Keep</p>		<p>continue or discontinue will be discussed during the Quality Assurance meeting. A. 2. The results of the checklist for the assignment sheets will be discussed during the quarterly Quality Assurance meeting with the Medical Director and the IDT team. The results of the random audits will be discussed during the QA committee meetings as well. The checklist and random audits will continue being monitored weekly for one month. If no further issues, then the assignment sheets will be audited on a monthly basis. Once 100% accuracy has been obtained and held for three months, whether to continue or discontinue will be discussed during the Quality Assurance meeting. The random audits to assure proper transfers will continue being completed weekly for at least 3 months. After that time, with compliance, the audits will be completed every month. Once 100% compliance has been achieved for 2 months, the QA committee will decide the necessity of continuing the audits. B. The ADON will discuss the results of obtaining code status's upon admission during the quarterly QA committee meeting. This will be ongoing. Respectfully requesting paper compliance for F282.</p>	

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	<p>environment free of clutter/obstructions qd. 2. Keep frequently used items within resident's reach. 3. Encourage resident to ask for assistance when needed qd [every day]. 4. Therapy as ordered."</p> <p>A care plan, with a start date of 8/27/14, indicated: "Problem: Resident requires assist with ADLS due to multiple diagnosis including but not limited to ESRD, chronic hypotension. Goal: Resident will be kept clean, dry, comfortable, and appropriately dressed and groomed at all times thru next review. Approach...9. Transfer to w/c [with] 2 [staff]."</p> <p>Nurse's notes, dated 9/1/14 at 3:55 a.m., indicated: "Staff was transferring res. from bed to wheelchair using gait belt. Wheelchair was locked, wheelchair moved backwards as res. attempted to sit. Staff lowered resident to floor. Denies pain. No injuries noted. T (temperature) 97.5 BP (blood pressure) 118/58 AHR (apical heart rate) 101 R (respirations) 18. Two staff assisted res. from floor to wheelchair. Res. ate 100% of breakfast. [Resident's physician] paged."</p> <p>An "Interdisciplinary Post-Fall Assessment", dated 9/1/14, indicated: "...Description of fall: Staff transferring from Bed to W/C - W/C locked & W/C</p>			

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	<p>moved back, staff lowered resident to floor. No injury. Orthostatic BP (if applicable): sitting 118/58. Diagnosis: ESRD (end stage renal disease), [with] dialysis, fx (fractured) L (left) ankle, cerebral aneurysm, diverticulosis, polycystic kidney disease.</p> <p>Medication/Side effects: Amiodarone, Plavix, Colace, Miralax, renal caps, Megace, Protonix. Recent medication changes: No. Pattern of current fall: Time of day: 3:55 a.m. Activity: W/C, staff assisted, transfer, witnessed.</p> <p>Location: Resident room, equipment: Wheelchair...Consider a probable cause for this fall based on review and investigation: W/C locks loose W/C from home of resident. Quality Assurance Review: Please review the most recent MDS/Care Plan completed for this resident. Are there any responses in Section G - Physical Functioning and Structural Problems...where staff have indicated the resident requires 1 or 2 person physical assistance to perform any of the indicated tasks ("support" column has a 2 or 3 coded)? Yes. If yes, does the current plan of care for this resident clearly indicate the level of assistance the resident requires? Yes.</p> <p>Recommendations from review by team (also record in resident medical record) Staff make sure W/C doesn't move [after] being locked, Maintenance tightened up</p>			

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	<p>locks on W/C. Care Plan revision. Yes...."</p> <p>On 9/23/14, at 2:06 p.m., Resident #43 was observed lying in bed on her left side. Her husband was present and putting away clean clothes for her. She said they usually use 2 of staff when they transfer her, and said she was sat on the floor once and didn't have any injuries, but couldn't remember how many staff were assisting her at that time.</p> <p>During an interview, on 9/24/14 at 10:00 a.m., the Director of Nurses (DON) indicated Resident #43 was being transferred with assist of one CNA on 9/1/14 when she was lowered to the floor.</p> <p>A CNA "Pack sheet" (assignment worksheet) was provided by the DON on 9/24/14 at 11:18 a.m. The Pack sheet indicated Resident #43 required assist of 2 to transfer when she was up in her wheel chair.</p> <p>A Policy for falls, with a last review date of 10/2005, was provided by the DON, on 9/24/14 at 1:26 p.m. The policy indicated, but was not limited to: "To identify patients at risk for falls, and to prevent injury or falls by identifying fall data for trends and patterns on Quality assurance fall time record. Procedure:</p>						

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	<p>Patients at risk for falls will be identified on MDS RAP sheet and care plan. Patients will be assessed upon admission with the MDS. To determine their risk for falling. Reassessment will be done if condition changes and with each MDS completed. An individual fall prevention care plan will be developed for each patient triggered for falls. The care plan will be implemented by staff for patients at risk using the appropriate safety measures, such as Therapy evaluation, bed alarm, chair alarm, mat by bed, or other appropriate measures...."</p> <p>During an interview, on 9/24/14 at 2:28 p.m., PTA (Physical Therapy Aid) #3 indicated nursing is supposed to use 2 of staff for her transfers.</p> <p>B. Review of the record of Resident #25, on 9/19/14 at 11:54 a.m., indicated the resident's diagnoses included, but were not limited to, end stage renal failure, diabetes, hypertension, severe valvular heart disease, severe aortic stenosis (narrowing), chronic obstructive pulmonary disease and chronic anemia.</p> <p>The record of Resident #25 indicated the resident was admitted to the facility on 5/7/14.</p> <p>Review of Resident #25's Physician orders dated, 5/7/14 indicated the resident</p>			

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	<p>did not have an physician order for code status.</p> <p>The Social Service progress note for Resident #25 dated, 5/7/14 at 4:35 p.m., indicated the resident was unable to answer questions. Social history or psychosocial assessment not completed. The resident does not answer appropriately to code status. "Writer will return." The note was signed by the Assistant Director Of Nursing (ADON).</p> <p>The record of Resident #25 had a posted note dated, 5/7/14 at 4:39 p.m., that indicated "could not get a clear response related to advance directives/code status." The resident has no power of attorney or health care representative. The posted note was signed by the ADON.</p> <p>The nursing note for Resident #25 dated, 5/9/14 at 5:32 a.m., indicated the when entering the resident's room, found her non responsive, cool to touch, pupils fixed. "Unable to palpate radial, brachial, or carotid pulses." "Unable to obtain a blood pressure." Respirations have ceased. The physician and sister was notified. The nursing note was signed by RN #1.</p> <p>Interview with the ADON on 9/23/14 at 12:55 p.m., indicated Resident #25 was</p>						

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	<p>not alert enough on 5/7/14 to go over the advanced directives. The ADON indicated the resident was talking but was nonsensical. The ADON indicated she attempted to go over the advanced directives with the resident a second time on 5/8/14, but the resident could not answer. The ADON indicated she called Resident #25's sister who was the next of kin, but the sister did not want to make the decision of code status for the resident.</p> <p>Interview with RN #1 on 9/23/14 at 1:25 p.m., indicated she did not do Cardiopulmonary Resuscitation (CPR) on Resident #25 because she had seen in the resident's record that when she was in the hospital the resident did not want to be a full code. RN #1 indicated she did know the resident had not signed her code status paperwork for the facility, but knew what the resident's wishes had been in the hospital.</p> <p>Interview with the ADON on 9/24/14 at 10:22 a.m., indicated she did not contact the physician to establish an doctors order for Resident #25's code status.</p> <p>The local hospital discharge summary for Resident #25 dated 5/6/14, (no time) indicated "on the day of her discharge , we discussed her code status at length</p>			

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F000323 SS=D	<p>and she agrees that with her baseline heart condition and ongoing medical comorbidities including end stage renal failure that she strongly desired to be a do not resuscitate.</p> <p>3.1-35(g)(2)</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.</p> <p>Based on observation, interview and record review, the facility failed to transport a resident in her wheelchair with the use of both foot rests as documented on her plan of care to prevent falls (Resident #8). The facility also failed to transfer a resident with assist of 2 staff, and locking the wheelchair wheels for a resident with a history of falls, a fractured left ankle, and a right below the knee amputation. This affected 2 of 4 residents reviewed for accidents. (Resident #43)</p> <p>Findings include:</p> <p>1. On 9/18/14 at 11:33 a.m., RN #1 indicated Resident #8 had fell in her</p>	F000323	WHAT CORRECTIVE ACTION(S) WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE. 1. All nursing personnel have been re-educated regarding the need to keep the footrests under her feet regardless of the distance she is being pushed due to her propensity to lean forward and possibly fall. They were also re-educated regarding the fact that she leans forward and to monitor that. She was seen by therapy and currently has a "busy apron" to assist in preventing her from leaning too far forward. In addition to that, a wheelchair has been ordered based on the recommendations from therapy to better deal with her leaning. This wheelchair was made to fit her	10/24/2014

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	<p>bedroom on 8/26/14.</p> <p>On 9/22/14 at 10:15 a.m., Resident #8 was observed being transferred from her wheelchair to her bed with the assistance of CNA #4 and CNA #5 and the use of a gait belt. CNA #5 locked Resident #8's wheelchair, placed a gait belt around her abdomen and moved her wheelchair foot rests to the side of the wheelchair prior to transfer. CNA #4 and CNA #5 assisted Resident #8 to stand, pivot and sit down on her bed. Resident #8 was assisted to lay down and positioned for comfort. She had a small scabbed area on her left cheek and a small abrasion above her left eyebrow.</p> <p>Resident #8's record was reviewed on 9/23/14 at 10:16 a.m. Diagnoses included but were not limited to Alzheimer's dementia and osteoporosis.</p> <p>Resident # 8's admission Minimum Data Set (MDS) assessment dated 7/14/14, indicated she was sometimes understood and she usually understood others. She scored 5 on her Brief Interview for Mental Status (BIMS) exam, indicating she was severely impaired for her daily decision making skills. She was totally dependent on 2 plus persons for transfers. She was totally dependent on 1 person for bed mobility, dressing, toileting and</p>		<p>specifically. 2. All nursing personnel have been re-educated regarding the requirement to follow the assignment sheets of each resident and to have 2 people transfer Resident #43. HOW OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE WILL BE IDENTIFIED AND WHAT CORRECTIVE ACTION(S) WILL BE TAKEN. 1. All residents who are at risk for falls could be affected. All nursing personnel have been re-educated regarding the need to keep the footrests under her feet regardless of the distance she is being pushed due to her propensity to lean forward and possibly fall. 2. All residents who are at risk for falls could be affected. All nursing personnel have been re-educated regarding the requirement to follow the assignment sheets of each resident and to have 2 people transfer Resident #43. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR. 1. All C.N.A assignment sheets for each resident have been updated and are being checked weekly to assure the information contained is accurate. 2. All C.N.A assignment sheets for each resident have been updated and are being checked weekly to assure the information contained</p>				

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	<p>personal hygiene. She did not walk in her bedroom.</p> <p>A nurse's note for Resident #8 dated 7/18/14 at 5 p.m., indicated Resident #8's wheelchair alarm was sounding and she was found in the foyer with her legs in a fetal position. A small red area was observed on the bridge of her nose related to her glasses. She was assisted to her bedroom and assessed and no other injuries were observed. She leaned over in her wheelchair frequently and was reminded by staff to sit up in her wheelchair so she would not fall out.</p> <p>An "Interdisciplinary Post-Fall Assessment" for Resident #8 dated 7/18/14, indicated she had an unwitnessed fall out of her wheelchair in the foyer. The assessment indicated she had been leaning over messing with her wheelchair foot rests.</p> <p>An intervention added to Resident #8's fall plan of care on 7/18/14, indicated her wheelchair foot rests would be pushed out to the side of her wheelchair unless staff were pushing her.</p> <p>A nurse's note for Resident #8 dated 8/26/14 at 8:10 p.m., indicated the nurse was called to the Resident's room by a CNA. The resident was lying on the</p>		<p>is accurate. In addition to this, random checks are being performed by the DON or her designee to watch transfers to assure that staff are being compliant and following directions as stated on the assignment sheets. HOW THE CORRECTIVE ACTION(S) WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR, I.E; WHAT QUALITY ASSURANCE PROGRAM WILL BE PUT INTO PLACE. 1. The results of the checklist for the assignment sheets will be discussed during the quarterly Quality Assurance meeting with the Medical Director and the IDT team. The checklist will continue being monitored weekly for one month. If no further issues, then the assignment sheets will be audited on a monthly basis. Once 100% accuracy has been obtained and held for three months, whether to continue or discontinue will be discussed during the Quality Assurance meeting. 2. The results of the checklist for the assignment sheets will be discussed during the quarterly Quality Assurance meeting with the Medical Director and the IDT team. The results of the random audits will be discussed during the QA committee meetings as well. The checklist and random audits will continue being monitored weekly for one month. If no further issues, then the</p>		

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	<p>floor on her left side in a fetal position between her bed and dresser. The CNA reported to the nurse Resident #8 had fell out of her wheelchair hitting her head. Resident #8 had a purplish raised area on her left side above her eye. No other injuries were observed. Resident #8 was assisted to bed.</p> <p>A nurse's note for Resident #8 dated 8/26/14 at 8:30 p.m., indicated she was transported to a nearby hospital for assessment and treatment.</p> <p>An "Interdisciplinary Post-Fall Assessment" for Resident #8 dated 8/26/14, indicated a staff member had taken Resident #8 to the bathroom and was pushing the resident in her bedroom and she leaned forward and fell out of her wheelchair.</p> <p>An intervention added to Resident #8's fall plan of care on 8/26/14, indicated Resident #8 would be observed closely when she was in her wheelchair and would be reminded not to lean forward when she was being pushed.</p> <p>A nurse's note for Resident #8 dated 9/19/14 at 4:35 p.m., indicated her personal alarm was sounding and the nurse was walking toward her and the resident fell out of her wheelchair landing</p>		<p>assignment sheets will be audited on a monthly basis. Once 100% accuracy has been obtained and held for three months, whether to continue or discontinue will be discussed during the Quality Assurance meeting. The random audits to assure proper transfers will continue being completed weekly for at least 3 months. After that time, with compliance, the audits will be completed every month. Once 100% compliance has been achieved for 2 months, the QA committee will decide the necessity of continuing the audits. Respectfully requesting paper compliance for F323.</p>				

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	<p>on her left side. Resident #8 had a 2 centimeter (cm) laceration on her left cheek and a 1/2 cm circular abrasion above her left eyebrow.</p> <p>A nurse's note for Resident #8 dated 9/19/14 at 4:55 p.m., indicated she was transported to a nearby hospital for assessment and treatment.</p> <p>An "Interdisciplinary Post-Fall Assessment" for Resident #8 dated 9/19/14, indicated staff observed her leaning forward in her wheelchair with her personal alarm sounding. She fell out of her wheelchair on her left side before staff could get to her.</p> <p>An intervention added to Resident #8's fall plan of care on 9/19/14, indicated Resident #8 would be referred to therapy for a possible drop seat or more appropriate seating.</p> <p>An interview with CNA #6 on 9/23/14 at 3:11 p.m., indicated on 8/26/14, she pushed Resident #8 from her bathroom to her bed. She stated Resident #8 "leaned over like she always does, because she is constantly leaning forward. She leaned forward and fell out onto the floor." She indicated when she positioned the wheelchair near Resident #8's bed was when she fell out onto the floor. She</p>			

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	<p>indicated Resident #8's wheelchair foot rests were swung to the sides of the wheelchair and she hadn't locked the wheelchair yet. She indicated Resident #8's wheelchair foot rests were left swung out to the sides of the wheelchair when she pushed her from the bathroom to her bed. She indicated she would place the wheelchair foot rests under Resident #8's feet if she were pushing her for a long distance but not necessarily from her bathroom to her bed. She indicated Resident #8 continued to lean forward a lot. 2. Resident #43's record was reviewed on 9/22/14 at 1:20 p.m. Physician's admission orders, dated 8/18/2014, indicated Resident #43 was admitted with diagnoses that included, but were not limited to, chronic low blood pressure, end stage renal disease, fractured left ankle, polycystic kidney disease, diverticulosis, and a right, below the knee amputation. The Physician's orders also indicated "Activity level: Transfer to w/c [with] 2."</p> <p>A "Fall Risk Assessment", dated 8/18/14, indicated a total score of 14, where a score above 10 represents a high risk for falls.</p> <p>An admission Minimum Data Set (MDS) assessment dated 8/27/14, indicated Resident #43 was cognitively intact,</p>						

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	<p>required extensive assistance of one person physical assist for bed mobility, extensive assist of two for transfers, did not ambulate, used a wheelchair for locomotion, balance was not steady, was only able to stabilize with staff assistance moving from a seated to a standing position and during surface to surface transfer (transfer between bed and chair or wheelchair), and had limitation in range of motion with impairment on one side of lower extremity (hip, knee, ankle, foot).</p> <p>A care plan, with a start date of 8/27/14, indicated: "Problem: Resident has potential for falls D/T (due to) fall history. Goal: [Resident #43] will remain free of falls qd (every day) thru next review. Approach: 1. Keep environment free of clutter/obstructions qd. 2. Keep frequently used items within resident's reach. 3. Encourage resident to ask for assistance when needed qd. 4. Therapy as ordered."</p> <p>A care plan, with a start date of 8/27/14, indicated: "Problem: Resident requires assist with ADLS due to multiple diagnosis including but not limited to ESRD, chronic hypotension. Goal: Resident will be kept clean, dry, comfortable, and appropriately dressed and groomed at all times thru next</p>			

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	<p>review. Approach...9. Transfer to w/c [with] 2 [staff]."</p> <p>Care plan: Problem: At risk for injury D/T chronic hypotension diagnosis. Goal: Resident will be free of injury thru next review. Approach: 1. Check and record B/P Q month and PRN. 2. Observe resident for fainting or dizzy spells, sudden increase in confusion, loss or use of hands/feet or slurred speech. If observed , alert charge nurse for notification of physician as needed. 3. Medicate as ordered. 4. Encourage as needed resident to change position slowly. 5. Consult with MD as needed. 6. 9/1/14 Therapy, maintenance to check brakes on w/c [with] staff make sure w/c doesn't move [after] being locked."</p> <p>Nurse's notes, dated 9/1/14 at 3:55 a.m., indicated: "Staff was transferring res. from bed to wheelchair using gait belt. Wheelchair was locked, wheelchair moved backwards as res. attempted to sit. Staff lowered resident to floor. Denies pain. No injuries noted. T (temperature) 97.5 BP (blood pressure) 118/58 AHR (apical heart rate) 101 R (respirations) 18. Two staff assisted res. from floor to wheelchair. Res. ate 100% of breakfast. [Resident's physician] paged."</p> <p>An "Interdisciplinary Post-Fall</p>			

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	<p>Assessment", dated 9/1/14, indicated: "...Description of fall: Staff transferring from Bed to W/C - W/C locked & W/C moved back, staff lowered resident to floor. No injury. Orthostatic BP (if applicable): sitting 118/58. Diagnosis: ESRD (end stage renal disease), [with] dialysis, fx (fractured) L (left) ankle, cerebral aneurysm, diverticulosis, polycystic kidney disease. Medication/Side effects: Amiodarone, Plavix, Colace, Miralax, renal caps, Megace, Protonix. Recent medication changes: No. Pattern of current fall: Time of day: 3:55 a.m. Activity: W/C, staff assisted, transfer, witnessed. Location: Resident room, equipment: Wheelchair...Consider a probable cause for this fall based on review and investigation: W/C locks loose W/C from home of resident. Quality Assurance Review: Please review the most recent MDS/Care Plan completed for this resident. Are there any responses in Section G - Physical Functioning and Structural Problems...where staff have indicated the resident requires 1 or 2 person physical assistance to perform any of the indicated tasks ("support" column has a 2 or 3 coded)? Yes. If yes, does the current plan of care for this resident clearly indicate the level of assistance the resident requires? Yes. Recommendations from review by team</p>						

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	<p>(also record in resident medical record) Staff make sure W/C doesn't move [after] being locked, Maintenance tightened up locks on W/C. Care Plan revision. Yes...."</p> <p>On 9/23/14, at 2:06 p.m., Resident #43 was observed lying in bed on her left side. Her husband was present and putting away clean clothes for her. She said they usually use 2 of staff when they transfer her, and said she was sat on the floor once and didn't have any injuries, but couldn't remember how many staff were assisting her at that time.</p> <p>During an interview, on 9/24/14 at 10:00 a.m., the Director of Nurses (DON) indicated Resident #43 was being transferred with assist of one CNA on 9/1/14 when she was lowered to the floor.</p> <p>A CNA "Pack sheet" (assignment worksheet) was provided by the DON on 9/24/14 at 11:18 a.m. The Pack sheet indicated Resident #43 required assist of 2 to transfer when she was up in her wheel chair.</p> <p>During an interview, on 9/24/14 at 2:28 p.m., PTA (Physical Therapy Aid) #3 indicated nursing is supposed to use 2 of staff for her transfers.</p>			

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	<p>A Policy for falls, with a last review date of 10/2005, was provided by the DON, on 9/24/14 at 1:26 p.m. The policy indicated, but was not limited to: "To identify patients at risk for falls, and to prevent injury or falls by identifying fall data for trends and patterns on Quality assurance fall time record. Procedure: Patients at risk for falls will be identified on MDS RAP sheet and care plan. Patients will be assessed upon admission with the MDS. To determine their risk for falling. Reassessment will be done if condition changes and with each MDS completed. An individual fall prevention care plan will be developed for each patient triggered for falls. The care plan will be implemented by staff for patients at risk using the appropriate safety measures, such as Therapy evaluation, bed alarm, chair alarm, mat by bed, or other appropriate measures...."</p> <p>A "Policy for Evaluating Cause of Resident Falls", with a last review date of 10/2005, was provided by the DON, on 9/24/14 at 1:26 p.m. The policy indicated: "All residents will be evaluated with a post fall assessment after a fall occurs to determine patterns or trends. Upon completion of post-fall assessment care plan will be reviewed and revised if necessary to address interventions to prevent reoccurrence.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155486	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/24/2014
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NAME OF PROVIDER OR SUPPLIER MIDDLETOWN NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 131 S 10TH ST MIDDLETOWN, IN 47356
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F000500 SS=D	<p>The post-fall assessments will be reviewed by the Quality assurance committee at each Quarterly meeting."</p> <p>3.1-45(a)(1) 3.1-45(a)(2)</p> <p>483.75(h) OUTSIDE PROFESSIONAL RESOURCES-ARRANGE/AGRMNT If the facility does not employ a qualified professional person to furnish a specific service to be provided by the facility, the facility must have that service furnished to residents by a person or agency outside the facility under an arrangement described in section 1861(w) of the Act or an agreement described in paragraph (h)(2) of this section.</p> <p>Arrangements as described in section 1861(w) of the Act or agreements pertaining to services furnished by outside resources must specify in writing that the facility assumes responsibility for obtaining services that meet professional standards and principles that apply to professionals providing services in such a facility; and the timeliness of the services.</p> <p>Based on record review and interview, the facility failed to obtain in writing the services provided by an outside dialysis center and ensure those services met professional standards for professionals providing services which affected 1 of 1 resident identified by the facility as requiring outpatient dialysis services.</p>	F000500	WHAT CORRECTIVE ACTION(S) WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE. Resident # 43 continues to go to the Dialysis Center of her choice. A contract has been signed between the Dialysis Center and the facility and is now in the contract book. HOW OTHER	10/24/2014

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	<p>(Resident #43)</p> <p>Findings included:</p> <p>Resident #43's record was reviewed on 9/22/14 at 1:20 p.m. Physician's orders, dated 8/18/14, indicated Resident #43 was admitted with diagnoses that included, but were not limited to, chronic hypotension, end stage renal disease, fractured left ankle, kidney disease, cerebral aneurysm, mitral valve prolapse, diverticulosis, and right below the knee amputation.</p> <p>The physician's orders, dated 8/18/14, also indicated these orders related to dialysis: AV fistula placement to left forearm, Lido/Prilocain Cream, topical, every Monday Wednesday, and Friday 45-60 minutes prior to dialysis, apply to fistula site, Epoetin Alfa (to increase hemoglobin) 4,000 units, intravenous every Monday, Wednesday, Friday, send to dialysis with patient.</p> <p>An admission MDS assessment dated 8/27/14, indicated Resident #43 was cognitively intact and received dialysis treatments before and after becoming a resident.</p> <p>During an interview on 10:22 a.m., the Director of Nurses indicated they don't</p>		<p>RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE WILL BE IDENTIFIED AND WHAT CORRECTIVE ACTION(S) WILL BE TAKEN. Any resident on dialysis could be affected. No other residents currently require dialysis. If one should, they will be given a choice as to where to obtain the Dialysis and a contract will be signed between that dialysis center and the facility. The contract will be kept in the Contract book. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR. The Social Service Director will be responsible for contacting the Administrator regarding any resident admitting with an order for dialysis or any current resident who should require dialysis. They will be given a choice regarding which center to use. At that time, if there is not a current contract with that Dialysis Center, one will be obtained. HOW THE CORRECTIVE ACTION(S) WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR, I.E; WHAT QUALITY ASSURANCE PROGRAM WILL BE PUT INTO PLACE. The Administrator will discuss the number of Dialysis patients and the contracts we have with the Dialysis Centers</p>				

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	<p>have a written contract with any of the dialysis centers, that the residents choose which one they go to and that's where they send them.</p> <p>3.1-13(m) 3.1-13(m)(1) 3.1-13(m)(2) 3.1-13(m)(3)</p>		<p>involved during the quarterly Quality Assurance Committee meeting with the Medical Director and the IDT team to ensure compliance. This will be ongoing. Respectfully requesting paper compliance for F500.</p>		