

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15A011	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/04/2014
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NAME OF PROVIDER OR SUPPLIER ESPECIALLY KIDZ HEALTH & REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 2325 S MILLER ST SHELBYVILLE, IN 46176
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F000000	<p>This visit was for a Recertification and State Licensure Survey. This visit included Investigation of Complaint # IN00146171.</p> <p>Complaint # IN00146171-Substantiated. Federal/State deficiencies related to the allegations are cited at F241.</p> <p>Survey dates: March 30, 31, April 1, 2, 3, 4, 2014.</p> <p>Facility number: 000273 Provider number: 15A011 AIM number: 100267870</p> <p>Survey team: Courtney Mujic, RN-TC Beth Walsh, RN (April 1, 2, 3, 4, 2014) Karina Gates, Medical Surveyor (March 31, April 1, 2, 3, 4, 2014) Tom Stauss, RN (March 30, 31, April 1, 3, 4, 2014)</p> <p>Census bed type: NF: 126 Total: 126</p> <p>Census payor type: Medicaid: 125 Other: 1</p>	F000000	<p>Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. The plan of correction is prepared and submitted because of requirement under and state and federal law. Please accept this plan of correction as our credible allegation of compliance. Please find enclosed this plan of correction for this survey. Due to the low scope and severity of the survey finding, please find the sufficient documentation providing evidence of compliance with the plan of correction. The documentation serves to confirm the facility's allegation of compliance. Thus, the facility respectfully requests the granting of paper compliance. Should additional information be necessary to confirm said compliance, feel free to contact me.</p>	

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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F000241 SS=D	<p>Total: 126</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on April 10, 2014 by Cheryl Fielden RN.</p> <p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY 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. Based on observation, interview and record review, the facility failed to ensure residents' dignity was maintained regarding their bed type for 2 of 5 residents reviewed for physical restraints. (Resident #86 and #52)</p> <p>Findings include:</p> <p>1. The clinical record for Resident #86 was reviewed on 4/2/14 at 1:30 p.m. The diagnoses for Resident #86 included, but were not limited to: Anoxia brain injury, epilepsy and spastic cerebral palsy with agitation.</p>	F000241	<p>F0241 Requires the facility to 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>1. One should note the diagnoses of Residents' #86 and #52 warranted non-traditional beds for resident safety. Due to the age of the beds and newer beds with safety features now available, a replacement bed for Resident #86 had already been ordered at the time of survey. The paperwork for his new bed was initiated at the end</p>	04/09/2014

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	<p>An observation of Resident #86 was made on 3/31/14 at 1:57 p.m. He was sitting in his bed. His bed was an encased crib with metal bars on all 4 sides and metal bars on top used as a canopy. He was encased in the crib and grabbing onto the bars.</p> <p>The 3/11/14 Bed/Sleeping Surface Safety Review indicated, "Therapy Review: Description of Current Bed/Sleeping Surface: (Name of Resident #86) is currently in a Pediacraft extra large crib with aluminum slats with metal top. Standard mattress with minimal gap between rails and mattress."</p> <p>An interview was conducted with LPN #5, the day shift nurse for Resident #86, on 4/2/14 at 11:19 a.m. regarding Resident #86's bed. She indicated, "He holds onto the bars. I don't like it. I feel like he's caged in it...I've been here 3 years, and he's always had that bed. I think it's kind of like an isolation thing. If we have visitors here, they look at him like 'Wow, he's in that type of bed.' I don't want people to look at the kids like that. They look at him like he's at the zoo."</p> <p>An interview was conducted with the Social Services Director (SSD) on 4/2/14</p>		<p>of March (see attachment A). The facility is awaiting bed arrival. Resident #52's bed had already been ordered and was replaced on April 4, 2014, during the survey (see attachment B). This information was provided to the survey team, thus, the facility requests this citation be deleted following IDR review.</p> <p>2.All residents have the potential to be affected. A complete audit was completed on all residents' beds to ensure resident dignity is being maintained. No further concerns were noted. See below for corrective measures.</p> <p>3.The Resident Rights policy and procedure was reviewed with no changes made. (See attachment C) The staff was inserviced on the above procedure with focus on dignity and identification/reporting should any such concerns be observed.</p> <p>4.The administrator will conduct rounds to ensure dignity is being enhanced for each resident regarding their bed. The administrator or his designee will utilize the administrative monitoring tool daily times for weeks, then weekly times four weeks, then every two weeks times two months, then quarterly thereafter until 100% compliance is obtained and maintained. (See attachment B) The audit findings and any corrective actions will be reviewed during the facility's quarterly quality assurance</p>				

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	<p>at 11:58 a.m. regarding Resident #86's bed. She indicated, "...that bed looks so institutionalized..."</p> <p>During another interview with the SSD on 4/4/14 at 1:25 p.m. regarding Resident #86's bed, she referred to Resident #86's bed and stated, "...those awful looking beds. I'm sure when people look in there, they're probably like "Oh my gosh."</p> <p>The Nurse Consultant provided information regarding the manufacturing date and dimensions of Resident #86's bed on 4/4/14 at 1:30 p.m. The dimensions were 35 inches by 80 inches and was manufactured in 1998.</p> <p>2. The clinical record for Resident #52 was reviewed on 4/2/14 at 1:40 p.m. The diagnoses for Resident #52 included, but were not limited to: impaired vision, profound mental retardation, cerebral palsy with agitation, seizures and spastic quadriparesis.</p> <p>An observation of Resident #52 lying in his bed was made on 4/2/14 at 1:45 p.m. His bed was an encased crib with metal bars on all 4 sides and metal bars on top used as a canopy. He was encased in the crib.</p> <p>The 3/11/14 Bed/Sleeping Surface Safety</p>		<p>meetings and the plan of correction will be adjusted accordingly, if warranted.</p> <p>5.The above corrective measures will be completed on or before April 9, 2014.</p> <p>IDR Rationale for F0241: The citation states, "The resident has a right to have dignity maintained regarding their bed types." Please note the administrative staff at Especially Kidz had identified the need for replacement beds, and the process had been set in motion prior to the arrival of the survey team. Regarding Resident #86, the paperwork for obtaining this bed was started on March 26, 2014. (See attachment A) Also, noted in this citation was resident #52. One should note this resident's bed had the paperwork started in January. (See attachment B) These beds are custom made to meet the specific needs of the resident and the process takes approximately 6 to 8 weeks. (See attachment D) The bed for resident #52 was delivered on April 4th, 2014, while the survey was still inprogress. Especially Kidz Health and Rehabilitation contends it provided sufficient evidence of action taken to replace beds prior to the arrival of surveyors and were awaiting the arrival of the beds, as evident by documentation provided. Especially Kidz respectfully requests this citation</p>				

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	<p>Review indicated, "Therapy Review: Description of Current Bed/Sleeping Surface: (Name of Resident #52) is in a Pediacraft crib bed with metal slats on four sides with top. The top slats have foam pads on each one. Mattress/crib is single size....Recommendations: He does not require the metal top (that he currently has) because of his inability to bear weight on his LE's (lower extremities)/stand up."</p> <p>An interview was conducted with LPN #6 on 4/2/14 at 1:48 p.m. regarding Resident #52's bed. She indicated, "He's had that bed at least 5 years, since I've been here...In general, the students from (names of 2 schools) have asked questions about the beds because they think it's weird and they haven't seen it (the bed type) before."</p> <p>During an interview with the SSD on 4/2/14 at 1:59 p.m. regarding Resident #52's bed, she indicated, "It's really the look of the bed that's the problem."</p> <p>During another interview with the SSD on 4/4/14 at 1:25 p.m. regarding Resident #52's bed, she referred to Resident #52's bed and stated, "...those awful looking beds. I'm sure when people look in there, they're probably like "Oh my gosh."</p>		be deleted.				

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F000253 SS=E	<p>This federal tag relates to Complaint # IN00146171.</p> <p>3.1-3(t)</p> <p>483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES</p> <p>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. Based on observation, interview, and record review, the facility failed to maintain a homelike environment for 1 of 40 resident's beds observed and 13 of 14 facility bathing rooms used. This affected 94 of 127 residents residing in the facility. (Resident #32)</p> <p>Findings include:</p> <p>1. During an random observation, on 4/1/14 at 1:55 p.m., Resident #32's crib was observed with rust colored marks on the back railings. The rust colored marks were on several of the metal horizontal railings and varied in length from finger</p>	F000253	F253 Requires the facility to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. 1. Resident#32's bed was sanded down and repainted. The bathing rooms were also painted utilizing an accent color and décor added to promote a homelike environment. 2. All residents have the potential to be affected. All residents' beds were assessed to ensure no rust is present. If any rust is noted, the bed will be repainted. No concerns were noted. See below for corrective measures.	04/09/2014			

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	<p>length to fingernail length.</p> <p>During an interview with the Administrator, on 4/1/14 at 2:40 p.m., the Administrator indicated the marks appeared to be rust on the railings and the marks did not maintain a homelike environment for Resident #32. The Administrator also indicated maintenance will paint the crib immediately.</p> <p>2. During a random observation of Bathing Room #5, with CNA #2 and #3 on 4/4/14 at 10:50 a.m., the Bathing Room was observed with a stainless steel bath and stark white walls throughout the whole room. One small picture was observed in the bathing room. Both CNA #2 and CNA#3 indicated they did not feel the Bathing Room was very homelike and they would not like to be bathed in there. They also indicated all the other Bathing Rooms were similar to this Bathing Room, with stark white walls, a stainless steel bath, and minimal pictures on the wall.</p> <p>At 10:54 a.m., on 4/4/14, Bathing Room #1 was randomly observed. Bathing Room #1 appeared to be very similar to Bathing Room #5. There was a stainless steel bath on one wall, stark white walls throughout the room, and minimal pictures on the walls.</p>		<p>3.The administrator was educated on the need to promote the facility looking homelike and keeping beds free from rust.</p> <p>4.The administrator or his designee will conduct rounds assessing bathing rooms to ensure that a homelike environment is being maintained as well as residents' beds are free of rust. The administrator or his designee will utilize the administrator monitoring tool daily times for weeks, then weekly times four weeks, then every two weeks times two months, then quarterly thereafter until 100% compliance is obtained and maintained. (See attachment E) The audits with any concerns identified/corrective actions taken will be reviewed during the facility's quarterly quality assurance meetings and the plan of correction will be adjusted accordingly, if warranted.</p> <p>5.The above corrective measures will be completed on or before April 14, 2014</p>				

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	<p>On 4/4/14, at 10:55 a.m., Unit Manager #4 indicated she felt the facility did the best they could with the bathing rooms, but the bathing rooms could use some paint to look more homelike. She also indicated all the bathing rooms look similar to Bathing Room #1.</p> <p>During a tour of Bathing Room #1 and Bathing Room #2, with the Administrator on 4/4/14 at 11:50 a.m., he indicated the facility had 14 bathing rooms. He further indicated 13 of the 14 bathing rooms looked similar to Bathing Room #1. The Administrator indicated 13 Bathing Rooms had stark white walls and minimal pictures on the walls. The Administrator also indicated one bathing room was newer than the other 13 Bathing Rooms and did not look like the other Bathing Rooms. The Administrator indicated he was more concerned with the function of the older Bathing Rooms when he designed them and never really thought about maintaining a homelike feel to them. The Administrator further indicated the older Bathing Rooms did not feel homelike and the Rooms did look "bleached out." He also indicated he can add the Bathing Rooms to the remodel list for the facility.</p> <p>On 4/4/14, at 12:00 p.m., the newer</p>						

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F000280 SS=D	<p>Bathing Room was observed with the Administrator. The walls were painted with a light taupe color and had colorful pictures hanging on the wall.</p> <p>At 12:07 p.m., on 4/4/14, a list of Residents who use the 13 older Bathing Rooms was provided by the Administrator. 94 residents were on the list. The Administrator indicated he did feel like the 13 older Bathing Rooms had the "1950's" institutional feel.</p> <p>3.1-19(f)(5)</p> <p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed</p>			

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	<p>and revised by a team of qualified persons after each assessment.</p> <p>Based on interview and record review, the facility failed to revise 2 nutrition care plans and a range of motion care plan and a device usage care plan for 4 of 17 residents reviewed for care plans. (Resident #32, #114, #34 & #68)</p> <p>Findings include:</p> <p>1. The clinical record for Resident #32 was reviewed 4/2/14 at 1:45 p.m. The diagnoses for Resident #32 included, but were not limited to: cerebral palsy, knee contractures, and seizure disorders.</p> <p>A telephone order, dated 3/11/14, indicated discontinue artificial sweeteners and diet desserts.</p> <p>A review of an Alteration in Nutritional/Hydration Status care plan, dated February 2014, indicated the interventions to have artificial sweeteners and diet desserts at meals and be on physician prescribed weight loss regimen.</p> <p>During an interview with the Care Plan Coordinator, on 4/2/14 at 3:20 p.m., she indicated the Dietary Manager was in charge of this specific nutritional care plan.</p>	F000280	<p>F280 Requires the facility to allow the resident the right, unless unjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>1. Resident #32's care plan was updated, removing the artificial sweeteners/diet desserts. Resident #114's care plan was updated and Mirtazapine was addressed. Resident #34's care plan was updated and was noted that nursing was to provide PROM. Resident #68's care plan was updated and the harness was care planned at this time.</p> <p>2. All residents have the potential to be affected. All of the residents' care plans were reviewed to ensure all updates to physician orders are present as well as adaptive equipment for wheelchairs were addressed on the care plan. No further concerns were noted. See below for corrective measures.</p> <p>3. The Care Plan Development and Review policy and procedure was reviewed with no changes made. (See attachment F) The staff was inserviced on the on the above procedure.</p> <p>4. The DON or his designee will review five care plans a day to ensure that all physician orders are updated on the care plan and that all adaptive equipment to</p>	04/09/2014			

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	<p>The Dietary Manager indicated, on 4/2/14 at 3:24 p.m., she forgot to revise the care plan with the discontinuation of artificial sweeteners/diet desserts and no longer being on a physician prescribed weight loss regimen.</p> <p>2. The clinical record for Resident #114 was reviewed 4/4/14 at 10:00 a.m. The diagnoses for Resident #114 included, but were not limited to: cerebral palsy, epilepsy, depression, and mood disorder.</p> <p>A Dietary Progress Note, dated 2/20/14, indicated, "...Rec (recommend) start appetite stimulant..."</p> <p>A Physician's Order, dated 2/25/14, indicated an order for mirtazapine 7.5 mg (milligram) at bedtime as an appetite stimulant.</p> <p>A review of all the care plans for Resident #114 were reviewed including a Nutritional care plan, dated February 2014, Eating/Swallowing care plan dated 1/28/14, and Choking care plan dated 1/28/14. None of the care plans indicated an intervention for mirtazapine as an appetite stimulant.</p> <p>During an interview with the Care Plan Coordinator, on 4/4/14 at 10:40 a.m., she indicated she didn't know about the order</p>		<p>wheelchairs are addressed on the care plan. The DON or his designee will utilize the nursing monitoring tool daily times four weeks, then weekly times four weeks, then every two weeks times two months, then quarterly thereafter until 100% compliance is obtained and maintained. (See attachment G) The audits and any concerns identified/corrective actions taken will be reviewed during the facility's quarterly quality assurance meetings and the plan of correction will be adjusted accordingly, if warranted.</p> <p>5. The above corrective measures will be completed on or before April 9, 2014.</p>	

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	<p>for the medication, but will add the medication to a dietary related care plan and create a care plan for the actual use of the medication.</p> <p>3. The clinical record for Resident #34 was reviewed 4/2/14 at 10:10 a.m. The diagnoses for Resident #34 included, but were not limited to: cerebral palsy, microcephaly, profound mental retardation, epilepsy, and contractures of all extremities.</p> <p>The February and March Physician's Orders indicated an order for the Restorative Nursing Program to perform passive range of motion (PROM) to bilateral upper extremities and bed positioning, as indicated, 5 times a week.</p> <p>During an interview with Restorative CNA #9, on 4/2/14 at 10:40 a.m., she indicated Resident #34 was discharged from the Restorative Nursing Program in January. She further indicated she was unsure what was being done for Resident #34 for PROM, but she thought the Clinical Nursing Staff was to perform PROM.</p> <p>On 4/2/14 at 11:44 a.m., the Director of Nursing (DoN) indicated the February and March Physician's Order for PROM from the Restorative Nursing Program</p>				

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F000318 SS=D	<p>was incorrect. He further indicated the Physician's Orders should've indicated PROM be done with activities of daily living (ADL), which was done by the Clinical Nursing Staff.</p> <p>A list of residents that were discharged from the Restorative Nursing Program on 1/31/14, was received from the DoN, on 4/2/14 at 12:30 p.m. The list indicated Resident #34 was discharged from the program.</p> <p>A care plan for Decreased Range of Motion, dated 3/3/14, indicated an intervention of PROM to bilateral upper extremities, 10 repetitions each daily, 5 times weekly.</p> <p>At 12:20 p.m., on 4/2/14, the DoN indicated there were no specific exercises or repetitions that were done for PROM during ADLs. The PROM came from raising arms/legs to put on clothes, changing undergarments, repositioning in bed, etc. The DoN also indicated the care plan for decreased range of motion did not reflect what the plan of care for Resident #34 was.</p> <p>483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion</p>			
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	<p>receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. Based on observation, interview and record review, the facility failed to follow physician's orders regarding splint use and passive range of motion for 1 of 3 residents reviewed for range of motion. (Resident #17)</p> <p>Findings include:</p> <p>The clinical record for Resident #17 was reviewed on 4/4/14 at 11:00 a.m. The diagnoses for Resident #17 included, but were not limited to: shaken baby syndrome, cerebral palsy with agitation, profound mental retardation, ventilator dependent, epilepsy, chronic vegetative state and spastic quadriparesis.</p> <p>The March, 2014 Physician's Orders for Resident #17 indicated, "Rehab 5 times per week for passive range of motion to bilateral upper extremities only" and "Nursing to implement bilateral resting hand splints as indicated 5 days/week."</p> <p>During an interview with Unit Manager #1 on 4/1/14 at 11:09 a.m., she indicated Resident #17 had contractures of all extremities.</p> <p>An observation of Resident #17 lying in</p>	F000318	<p>F318 Requires the facility to ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or prevent further decrease in range of motion.</p> <ol style="list-style-type: none"> 1. Resident #17's restorative programs were reviewed. Resident #17 will have range of motion and splint use provided per physician's order. 2. All residents have the potential to be affected. All of the residents' restorative programs were reviewed to ensure the programs were being followed per the physician's order. No further concerns were noted. See below for corrective measures. 3. The Physician's Order policy and procedure was reviewed with no changes made. (See attachment H) The staff was inserviced on the on the above procedure. 4. The DON or his designee will review five restorative programs a day to ensure that restorative programs are being followed per the physician's order. The DON or his designee will utilize the nursing monitoring tool daily times four weeks, then weekly times four weeks, then every two weeks times two months, then quarterly thereafter until 100% compliance is obtained and maintained. The audits and any 	04/09/2014			

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	<p>bed was made on 4/1/14 at 10:00 a.m. No hand splint devices were observed.</p> <p>An observation of Resident #17 lying in bed was made on 4/4/14 at 11:38 a.m. No hand splint devices were observed.</p> <p>During an interview with CNA #7 on 4/4/14 at 11:37 a.m., she indicated therapy came to see Resident #17 everyday. She stated, "He also wears those soft gray hand splints for 2 hrs a day."</p> <p>The form titled "Restorative Program" with a start date of 11/8/12 for Resident #17 was reviewed on 4/4/14 at 11:55 a.m. It indicated, "Resident's Current Status: Receives PROM (passive range of motion) Problem: at risk for contractures without intervention. Program Specific Interaction: After PROM to BUE (bilateral upper extremities), implement (B) (bilateral) resting hand splint to promote bilateral neutral positioning of wrist; increase ROM; decrease contractures; wear schedule: as tolerated, up to 4 hours. Monitor skin integrity before, during and after use. Goal: Resident will tolerate use of (B) resting hand splints to foster bilateral neutral positioning of the wrist; increase ROM showing no negative signs/symptoms of discomfort or pain</p>		<p>concerns identified/corrective actions taken will be reviewed during the facility's quarterly quality assurance meetings and the plan of correction will be adjusted accordingly, if warranted.</p> <p>5. The above corrective measures will be completed on or before April 9, 2014.</p>	

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	<p>through next review."</p> <p>The March, 2013 Restorative Nursing Tracking Log indicated Resident #17's left and right hand splints were applied after PROM was performed as follows:</p> <p>Week 1= 2 times Week 2= 3 times Week 3= 5 times Week 4= 4 times</p> <p>The March, 2014 Restorative Monthly Summary for Resident #17 indicated, "(Name of Resident #17) receives 1 set of 5-7 reps (repetitions) of PROM on BUE's only, then he wears his hand splints for up to 4 hrs (hours) as tolerated. (Symbol for "no") concerns." This section of the form was signed by the DON (Director of Nursing). The Comments section of the form indicated, "Alter schedule (sic)" for the following dates: 3/6/14, 3/12/14, 3/14/14, 3/26/14 and 3/31/14. This section of the form was also signed by the DON.</p> <p>An interview was conducted with Restorative Aide #8 on 4/4/14 at 12:00 p.m., regarding the above log and summary. She indicated, "Each of us have a number of residents and work 7.5 hours (per day). The rule is we alternate the kids, and cannot go 2 days in a row</p>						

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	<p>without doing passive range of motion. We're down one person, so we cannot do 5 times weekly with being down 1 staff. Now, the expectation is don't miss 2 consecutive days. He (Resident #17) should not be alter schedule that many times which shows we are short staffed. We've been short staffed 3 or 4 months. (Name of another restorative aide) broke her arm roughly 6 weeks ago and hasn't been working."</p> <p>An interview was conducted with the DON on 4/4/14 at 12:18 p.m. regarding the tracking logs indicating Resident #17 was not receiving PROM or wearing his hand splints 5 times weekly as ordered. He indicated, "In my mind the order is being fulfilled with diaper changes every 2 hours and prn (as needed), turn and reposition every 2 hrs and prn, and through baths daily. As far as the hand splints, I'll have to ask the unit manager (Unit Manager #1) about that."</p> <p>During another interview with the DON on 4/4/14 at 1:41 p.m. regarding Resident #17's hand splint wear, he stated, "I think that company is in trouble. The company did not inform (name of Unit Manager #1) that they could not do the passive range of motion and splints, and that nursing needed to pick it up. No one told us, so he hasn't been getting it. There</p>						

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F000323 SS=D	<p>was an error somewhere. They should be fulfilling their contract. I sign the monthly (PROM) sheets. There's my signature, but I wasn't aware it wasn't being done. I see these 'alter schedule' dates align with the dates its not being done."</p> <p>3.1-42(a)(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. Based on observation, interview, and record review, the facility failed to ensure appropriately sized siderails were utilized on 1 of 40 resident beds reviewed for safety in order to prevent injury from potential entrapment. (Resident #85.)</p> <p>Findings include: Resident #85's clinical record was</p>	F000323	<p>F323 Requires the facility to ensure that the resident environment remains free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>1.Resident #85's side rails have a mesh bag covering the siderail. Resident #85 was offered another bed prior to the time of survey</p>	04/09/2014

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	<p>reviewed on 4/01/2014 at 10:02 am. Resident #85's diagnoses included but were not limited to; Spina Bifida, anxiety, treatment resistant depression, tracheostomy, asthma, neuropathy, diabetes, migraine headaches, Arnold-Chiari malformation (pressure around the spinal cord), paraplegia, and history of seizures.</p> <p>An observation on 4/01/2014 at 11:44 a.m., indicated Resident #85's siderail's open spaces appear to be too large, and there was no 'bag cover' (mesh material specifically fitted snug over the siderail to prevent access to the openings) covering the siderail.</p> <p>An Ancillary MD order on the March Physician's Orders Recapitulation, not dated, indicated, "PT (patient) is medically incapable of understanding or exercising his rights- no".</p> <p>A care plan, most recently updated on 4/1/2014, indicated, "ADL (activities of daily living) Assist Required. Interventions: Resident utilizes 1/2 side rails up x (times) 2- reasoning is for siderails is (sic) to aid resident in positioning self."</p> <p>An interview with the Administrator (ADM), on 4/1/2014 at 12:30 p.m., in</p>		<p>and during the survey; however, voices a desire to keep his current bed, as he is comfortable with its use/function.</p> <p>2.All residents have the potential to be affected. Residents' siderails were assessed to ensure there is in safety issues. No further concerns were noted. See below for corrective measures.</p> <p>3.The staff was inserviced on the safety regulation regarding spacing in the siderails and covering any rail that did not meet FDA guidelines with a mesh bag to provide safety.</p> <p>4.The administrator his designee will conduct daily rounds to ensure that all mesh bags are present on the siderails that do not meet FDA guidelines. The administrator or his designee will utilize the administrative monitoring tool daily times four weeks, then weekly times four weeks, then every two weeks times two months, then quarterly thereafter until 100% compliance is obtained and maintained. The audits and any concerns observed/corrective actions taken will be reviewed during the facility's quarterly quality assurance meetings and the plan of correction will be adjusted accordingly, if warranted.</p> <p>5.The above corrective measures will be completed on or before April 14, 2014. IDR Rationale: The facility respectfully disagrees that it failed</p>				

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	<p>reference to whether or not a new bed was considered for Resident #85 indicated, "I never considered that." He indicated the bed itself was electric, and the resident was able to control the bed position with a touch button control that is located on the side rail itself. "The side rail cannot be removed or replaced because it would destroy the functioning of the bed, and then that would diminish his ADL's (activities of daily living), what he can do for himself, which is already very little. The only other bed we have available is the older kind, that you have to hand crank the positioning, which he would not be physically able to do."</p> <p>An "Informed Consent Non-Use of Bed Side Rail Covers" document, dated 3/5/2014, indicated, "Potential Zones of Entrapment: Zone 1: Within the Rail. Per the FDA recommendations to prevent entrapment, "Zone 1 is any open space within the perimeter of the rail. Openings in the rail should be small enough to prevent the head from entering...The HBSW and IEC recommend that the space be less than 120 mm (4 3/4 inches), representing head breadth. I acknowledge the electric bed of choice and in use at this time has side rail space(s) which are contradictory to FDA recommendations. I acknowledge the facility has provided appropriate side rail covers for use, and</p>		<p>to meet the intent of F323, as the facility had addressed the issue of potential entrapment risk with the resident and had offered an alternate bed, yet the resident had refused. The balance between resident rights and safety must be evaluated. The facility has submitted a summary of the resident's preference and efforts of the facility for review during IDR determination (see Attachment I). The facility respectfully requests this citation be deleted. The citation states, "The facility is to ensure appropriately sized side rails were utilized for safety in order to prevent injury from potential entrapment." Please note, the Especially Kidz administrative staff recognized that one section of the side rail did not meet FDA guidelines and addressed this concern with the resident prior to the annual survey. Please also note, the resident is his own legal representative and has a BIMS score of 15. The administrative staff met with resident #85 and explained the risk factors of the rail gap not meeting the FDA guidelines for entrapment. (See attachment I1) The resident acknowledged understanding of the risk factors and asked if he could further write a statement expressing his desire to continue to use his bed without the mesh covers. (See attachment I2) Resident #85 owns this bed and he feels like it</p>		

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	<p>has explained their use and necessity to prevent potential entrapment. I acknowledge and understand the ramifications of my desire to continue to occupy the current electric bed in use and my refusal to have the side rail covers provided by the facility in place at all times. I acknowledge that should I desire the covers at any time, I can request them from staff who will place them on the side rails accordingly." The document was signed by Resident #85 and on the backside of the document the resident indicated the following, "I have been advised of the use for the bed rail covers, but I am a (age of Resident #85) year old man and am able to make my own decided (sic). I feel the bed rail covers are unnecessary in my case since I do not move around a lot in my bed also I am too big to fit through the cracks. Sincerely, (Resident #85's name) P.S. I have rights. Don't ask me again, please."</p> <p>An interview with the ADM, on 4/2/2014 at 2:50 p.m., indicated he will ensure the 'bag cover' stays on the siderail.</p> <p>An interview with the ADM on 4/3/2014 at 9:30 a.m., indicated there is only one section of the rail that measures too big, it measures 5.5 by 7 inches wide, which is too wide per FDA regulations.</p>		<p>is his right to use the bed in which he feels safe and secure. He has used this bed for years and is comfortable with how to operate it and position himself in it to aide with his breathing. Further, the resident has had no injury while using the bed. The administrator, at this time, offered the resident a different bed on which the mesh bags were not needed, and the resident declined a different bed. The resident continued to be adamant in his desire to keep his personal bed. On 4/3/14, the administrator and nurse consultant once again approached the resident about the issue of his side rails. The resident did not want to change beds, did not want to use a mesh cover because it interferes with the controls, and felt like his rights were being violated. (See attachment I3) The resident also, at this time, asked that the ombudsman be contacted on his behalf. The administrator placed a call to the ombudsman at this time. The resident once again on this date asked if he could write a letter regarding his right to have this bed without the mesh covers. (See attachment I4) The resident stated, "I feel humiliated that I am being forced to follow this law when I am well aware of what I want." The resident also had a discussion with his primary care physician regarding the safety of his bed and the desire to continue to use his own bed. (See</p>				

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	<p>A drawing, provided by the ADM on 4/2/2014 at 3:15 p.m., indicated there are five openings on the side rail. The opening closest to the right edge measured, "5 1/2 inches across and 7 1/2 inches tall."</p> <p>An ADL Assist Required care plan indicated, "Interventions: Resident utilizes 1/2 side rails up x 2- reasoning is for siderails is (sic) to aid resident in positioning self."</p> <p>A letter, written by Resident #85, and provided by the ADM on 4/4/2014 at 9:30 a.m., indicated, "To ISDH (Indiana State Department of Health), This is my bed. I have been told despite my wishes, I have no choice but to have my upper rail draped. This would render my bed controls inoperable. Please note that my bed rails are legal except for one upper left hand corner gap that is 5.5 inches. I don't want another bed, I want this one. By doing this, I feel like my rights are violated. I am a grown man and can make my own decisions. This goes further than common sense. I don't see how the head of a (age of Resident #58) year old man can fit through a 5.5 inch gap, let alone a man with hydrocephalus. Finally, I feel humiliated by this law. Sincerely, (Resident #85's name.)"</p>		<p>attachment 15) The Medical Director also spoke to Resident#85 regarding his bed and the Medical Director supports the right of the resident is being violated. (See attachment 16). Especially Kidz administrative staff serve as an advocate for the resident and have a duty to protect his rights. The staff has numerous times spoken with the resident regarding the bed and the residentclearly knows the risk, however it is his right to make his own informed decision, as he is of sound mind. The ombudsman has since visited with the resident and has provided a written statement as to the issue in regard to the rights of the resident (See attachment 17). Especially Kidz Health and Rehabilitation contends it provided sufficient evidence of action taken to educate the resident on the FDA guidelines and to allow the resident the right to make his own informed decision as evident by documentation provided. Especially Kidz respectfully requests this citation be deleted.</p>				

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	<p>The "<u>Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment-Guidance for Industry and FDA Staff,</u>" issued March 10, 2006, indicates the FDA (Food and Drug Administration) recommends openings within the rail, between rail supports, under the rail or next to a single rail support and between the rail and mattress should be small enough to prevent the head from entering or being entrapped. The "Hospital Bed Safety WorkGroup (HBSW)" and the "International Electrotechnical Commission (IEC)" along with the FDA recommend the space be less than 4 ¾ inches.</p> <p>3.1-45(a)(1)</p>						
F000329 SS=D	<p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse</p>						

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	<p>consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on interview and record review, the facility failed to consider consultation of a Psychiatrist in the treatment of a resident's treatment resistant depression for 1 of 5 residents reviewed for unnecessary medications. (Resident #85).</p> <p>Findings include:</p> <p>Resident #85's clinical record was reviewed on 4/01/2014 at 10:02 a.m. Resident #85's diagnoses included but were not limited to; Spina Bifida, anxiety, treatment resistant depression, tracheostomy, asthma, neuropathy, diabetes, migraine headaches, Arnold-Chiari malformation (pressure around the spinal cord), paraplegia, and history of seizures.</p> <p>Review of the resident's current April</p>	F000329	<p>F329 Requires the facility to ensure that each resident's drug regimen be free from unnecessary drugs.</p> <p>1. Resident #85 was referred to a Psychiatrist. The facility will follow to promote being seen by the psychiatrist to allow a thorough review of current medications ordered and plan of care in place to treat the resident's depression.</p> <p>2. All residents have the potential to be affected. Residents' mood and behavior logs were reviewed to ensure residents are receiving mental health services as needed. No further issues were noted. See below for corrective measures.</p> <p>3. The staff was inserviced on reviewing mood and behavior logs and identification of a resident who is having increased behavior or depressive</p>	04/09/2014

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NAME OF PROVIDER OR SUPPLIER ESPECIALLY KIDZ HEALTH & REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 2325 S MILLER ST SHELBYVILLE, IN 46176
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	<p>MD orders indicated he received the following medications; Abilify 5mg (an antipsychotic medication), cymbalta 60mg (an antidepressant medication, and Wellbutrin SR 150mg twice a day (an antidepressant medication).</p> <p>A care plan, most recently updated dated 4/1/2014, indicated, "Problem: (Resident #85's name) has a dx. (diagnosis) of depression and anxiety. He verbalizes feelings of sadness and loneliness (sic) at times. Interventions: Review mood, behavior, and medications quarterly. Provide meds per MD order."</p> <p>An MD note, dated 12/13/2013, indicated, "Re: Psychoactive Medication Review for (Resident #85) is an emancipated adult male...He suffers Migraine headaches partially due to Arnold-Chiari Syndrome, and chronic sleep disturbance secondary to pain and sleep apnea. (Resident #85's name) requires long term use of Wellbutrin and Clonazepam for anxiety induced migraine headaches. He has treatment resistant depression that has required Ability (sic) to as an adjunct therapy to antidepressants. He has had a good response lately to Cymbalta...This letter is to attest that I feel it would be detrimental to (Resident #85's name) to challenge his current medication regimen</p>		<p>symptoms. The staff was instructed if there is an increase in behaviors or depressive symptoms, a referral should be made to the appropriate mental health service.</p> <p>4.The DON or his designee will review mood and behavior forms to ensure that residents are receiving mental health services as needed. The DON or his designee will utilize the nursing monitoring tool daily times four weeks, then weekly times four weeks, then every two weeks times twomonths, then quarterly thereafter until 100% compliance is obtained and maintained. The audits and any concerns/corrective actions taken will be reviewed during the facility's quarterly quality assurance meetings and the plan of correction will be adjusted accordingly, if warranted.</p> <p>5.The above corrective measures will be completed on or before April 14, 2014.</p>	

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	<p>at this time, or at any time in the near future."</p> <p>An interview with the Director of Nursing, on 4/2/2014 at 11:25 a.m., indicated, "He's (Resident #85) reviewed by a behavioral Psychologist quarterly. He's seen a social worker here in house for counseling, but no Psychiatrist though.</p> <p>An interview with Unit Manager #1, on 4/2/2014 at 12:00 p.m., indicated, "We don't go in the room (Resident #85's room) when the MD comes to speak with him, because he can speak for himself and make his own decisions. The MD and the resident talk to each other privately, so I don't know for sure if they've ever discussed the possibility for referring him to see a Psychiatrist. I will call the MD right now, after I ask the resident if its ok, to see what the MD thinks about a Psychiatrist referral."</p> <p>Further interview with the Unit Manager #1, on 4/3/14 at 11:22 a.m., indicated the resident's MD is scheduled to be here in person on Friday and she will ask him at that time whether or not he has considered sending (Resident #85) to a Psychiatrist. She knows she has not brought up the issue before and they haven't questioned the "resistant</p>						

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F000514 SS=D	<p>depression". She is sure the resident hasn't seen a Psychiatrist in the past.</p> <p>A telephone interview with the MD, on 4/4/2014 at 12:03 p.m., indicated,"He has not seen a Psychiatrist for his treatment resistant depression. I know I offered that option in the past, but its been quite some time ago, I don't remember how long exactly but its definitely been awhile. I haven't revisited the option with him since that time. When I did bring it up his opinion was that his depression was very situational, however, he's always kind of been depressed and I've tried multiple different medication regimens to try to treat it. I think at the time he was having some difficulties with his wife, but he might be open to it now. I wouldn't be opposed to referring him to a Psychiatrist. That might be a good idea."</p> <p>3.1-48(a)(3)</p> <p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCE SSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that</p>				

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	<p>are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on interview and record review, the facility failed to maintain accurate Physician's Orders for 1 of 17 residents reviewed for clinical records. (Resident #34)</p> <p>Findings include:</p> <p>The clinical record for Resident #34 was reviewed 4/2/14 at 10:10 a.m. The diagnoses for Resident #34 included, but were not limited to: cerebral palsy, microcephaly, profound mental retardation, epilepsy, and contractures of all extremities.</p> <p>The February and March Physician's Orders indicated an order for the Restorative Nursing Program to perform passive range of motion (PROM) to bilateral upper extremities and bed positioning, as indicated, 5 times a week.</p> <p>During an interview with Restorative CNA #9, on 4/2/14 at 10:40 a.m., she</p>	F000514	<p>F514 Requires the facility maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <ol style="list-style-type: none"> 1. Resident #34's physician's order was clarified and nursing staff is to perform PROM during ADL care. 2. All residents have the potential to be affected. Residents' physician's order sheets were reviewed to ensure restorative program orders were correct. No further issues were noted. See below for corrective measures. 3. The Physician's Order policy and procedure was reviewed with no changes made. (See attachment H) The staff was inserviced on the on the above procedure. 4. The DON or his designee will review all new physician orders to ensure that the order is transcribed correctly on the physician order sheets. The DON or his designee will utilize the 	04/09/2014

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	<p>indicated Resident #34 was discharged from the Restorative Nursing Program in January.</p> <p>On 4/2/14 at 11:44 a.m., the Director of Nursing (DoN) indicated the February and March Physician's Order for PROM from the Restorative Nursing Program was incorrect. He further indicated the Physician's Orders should've indicated PROM be done with activities of daily living (ADL). The DoN indicated the Unit Manager should've caught the documentation error for PROM when they reviewed the Physician's Orders.</p> <p>A list of residents that were discharged from the Restorative Nursing Program on 1/31/14, was received from the DoN, on 4/2/14 at 12:30 p.m. The list indicated Resident #34 was discharged from the program.</p> <p>3.1-50(a)(2)</p>		<p>nursing monitoring tool daily times four weeks, then weekly times four weeks, then every two weeks times two months, then quarterly thereafter until 100% compliance is obtained and maintained. (See attachment D)</p> <p>The audits and concerns/corrective actions taken will be reviewed during the facility's quarterly quality assurance meetings and the plan of correction will be adjusted accordingly, if warranted.</p> <p>5. The above corrective measures will be completed on or before April 14, 2014.</p>		