

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155272	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/29/2011
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NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-CASTLETON	STREET ADDRESS, CITY, STATE, ZIP CODE 5226 E 82ND ST INDIANAPOLIS, IN46250
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F0000	<p>This visit was for Investigation of Complaints IN00101198 and IN00101278.</p> <p>This visit was in conjunction with the PSR (Post Survey Revisit) to the Investigation of Complaints IN00097927 and IN00098919.</p> <p>Complaint IN00101198 - Substantiated. Federal/State deficiency related to the allegation is cited at F157.</p> <p>Complaint IN00101278 - Substantiated. Federal/State deficiency related to the allegation is cited at F323.</p> <p>Unrelated deficiencies cited.</p> <p>Survey dates: December 27, 28 &amp; 29, 2011</p> <p>Facility Number: 000172 Provider Number: 155272 AIM Number: 100267130</p> <p>Survey Team: Mary Jane G. Fischer RN</p> <p>Census Bed Type: SNF/NF: 112 Total: 112</p>	F0000	F0000The creation and submission of this Plan of Correction doesnot consitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 be considered the Credible Allegation of Compliance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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	<p>Census Payor Type: Medicare: 23 Medicaid: 67 Other: 22 Total: 112</p> <p>Sample: 6</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review 1/03/12 by Suzanne Williams, RN</p>				

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F0157 SS=D	<p>A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on record review and interview, the facility failed to ensure a resident's physician and family members were notified of a significant change which had the potential to require physician intervention for 3 of 5 residents reviewed in a sample of 6. [Resident's "A", "C", and "B"].</p>	F0157	F157It is the practice of this facility to ensure a resident's physician and family members are notified of changes in a timely manner. 1. Corrective Action: Resident A and C currently reside in the facility. Both have been reviewed by the Registered Dietician and the attending physician. Resident B was	01/23/2012

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	<p>Findings include:</p> <p>1.) The record for Resident "A" was reviewed on 12-27-11 at 11:50 a.m. Diagnoses included, but were not limited to, diabetes insipidus, seizure disorder, adrenal insufficiency and acute renal failure. These diagnoses remained current at the time of the record review.</p> <p>The record indicated the resident received a Regular No Added Salt diet.</p> <p>The "Individual Resident Weight History" for the year 2011 indicated a re-admission weight on 08-03-11 of 288.0 lbs, with a subsequent weight recorded on 08-16-11 of 259.0 lbs. The record lacked documentation of a "reweight" or "notification of MD [Medical Doctor] &amp; Family in Resident Progress Notes." The "weight history" lacked a weight for the month of September 2011.</p> <p>A review of the resident's monthly weights indicated the following: October 5, 2011 - 260.6 lbs. [pounds] November 7, 2011 - 261.4 lbs. December 248.4 lbs (Reweigh) 236.6 lbs</p> <p>During an interview on 12-28-11 at 12:40 p.m., the resident's concerned family member indicated the family was unaware</p>		<p>discharged home. 2. Identifying Others: Weight records have been reviewed, appropriate re-weights have been obtained, MD/family notification of changes have been made as appropriate by RD.3. Systematic Changes: Staff was educated on the policy and procedure for obtaining weights, nutritional risk, change of condition, (form includes notification of physician), and notification by the DNS/SDC. Weekly/monthly weights will be reviewed by the RD with discrepancies addressed with reweight. RD will notify both physician and family of change as appropriate. IDT meets weekly to review those at Nutritional Risk.4. Monitoring: RD/DNS/ED to monitor weights weekly, monitor change of condition forms for completeness weekly x4 and monthly until substantial compliance is achieved. (Criteria in audit tool will be 100%)5. RD/DNS/ED to ensure compliance by 1-23-12.</p>		

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	<p>the resident had lost this significant amount of weight, and further questioned if the physician had been notified.</p> <p>Further review of the record lacked documentation the physician had been aware of the weight loss.</p> <p>2. The record for Resident "C" was reviewed on 12-28-11 at 10:30 a.m. Diagnoses included, but were not limited to, acute intracranial bleed, hypertension, recent craniotomy and right hemiparesis. These diagnoses remained current at the time of the record review.</p> <p>At the time the resident was admitted to the facility, 11-17-11, the admission weight was recorded at 248.5 lbs. The weight recorded for 11-24-11 was documented at 241.5 lbs. The record lacked a "Reweight" or notification of the resident's physician or concerned family member.</p> <p>The "Individual Resident Weight History" for December 5, 2011 was 245.5 lbs and the 12-12-11 weight was documented at 235.6 lbs. The record lacked documentation of a "reweight" or physician/family notification.</p> <p>3. The record for resident "B" was reviewed on 12-27-11 at 1:50 p.m.</p>				

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	<p>Diagnoses included, but were not limited to, multiple sclerosis, depressive disorder, quadriplegia and malnutrition. These diagnoses remained current at the time of the record review.</p> <p>The record indicated the resident received a Regular diet with house shakes three times a day with meals.</p> <p>At the time the resident was admitted to the facility, 10-25-11 the resident's weight was documented as 120.0 lbs. A subsequent weight on 11-21-11 was recorded at 94.5 lbs. The "Individual Resident Weight History" lacked documentation of a "reweight" or physician/family notification.</p> <p>4. During an interview on 12-29-11 at 8:00 a.m., the Executive Director indicated the nursing staff should have reweighed the residents and notified the physician and concerned family members as appropriate.</p> <p>5. Review of facility policy on 12-28-11 at 8:00 a.m., and titled "Condition Change of a Resident," dated 10-31-06 indicated "Resident change of condition is identified for proper treatment implementation. The physician is informed of resident events and/or change in resident's condition. Notify family</p>				

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	<p>member/responsible party of resident's condition."</p> <p>6. Review of facility policy on 12-28-11 at 8:00 a.m., and titled "Nutritional Risk, Nutrition Problem and/or Significant Change," and dated 08-31-11, indicated "A patient who demonstrates a risk for decline in nutritional status and/or is identified as having a nutrition problem will have appropriate interventions established and implemented to improve or maintain nutritional status. 1.) Identify patients newly admitted or re-admitted with a risk for a decline in nutritional status and/or current nutrition problem. 5.) Identify patients needing at least monthly monitoring/evaluation or if deemed necessary, more frequently. Patients that may be included, but are not limited to f.) Having a significant undesirable weight loss or gain. 7.) Notify and consult with physician regarding patient's current nutritional status or significant change in nutritional status. Documentation Guidelines: 8.) Document notification of physician and family member/responsible party if has significant nutritional change that may include weight loss/gain."</p> <p>7. Review of facility policy on 12-28-11 at 9:50 a.m., and titled "Measuring and Documenting Height and Weight," and</p>				

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	<p>dated 10-31-10 indicated "Height and weight is utilized in conjunction with other information to calculate estimated energy; protein and fluid needs and to identify the patient's ideal/desired weight range, risk for weight loss/gain and/or current nutritional problems. Measuring weight: 10.) Balance scales to zero before and after weighting - if a patient has a 5 pound or more difference from the most recent weight, the scale shall be re-calibrated and the weight taken again to confirm accuracy. Request a licensed nurse to verify re-weight for accuracy and documentation purposes. 22.) If a significant unintended weight change or insidious weight loss is identified, identify possible causes, determine goals and interventions, and complete a significant change of status if appropriate. Notify physician and family member/responsible party and document in patient's record ..."</p> <p>This Federal deficiency relates to Complaint IN00101198.</p> <p>3.1-5(a)(2)</p>				

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F0279 SS=D	<p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). Based on observation, interview and record review, the facility failed to ensure a plan of care was developed for a resident who required hydration needs for 1 of 1 resident with a specific diagnosis which required hydration in a sample of 6. [Resident "A"].</p> <p>Findings include:</p> <p>The record for Resident "A" was reviewed on 12-27-11 at 11:50 a.m. Diagnoses included, but were not limited to, diabetes insipidus, seizure disorder, adrenal insufficiency and acute renal failure. The record also indicated the resident was blind. These diagnoses remained current</p>	F0279	<p>F 279It is the practice of this facility to develop comprehensive care plans for each resident that includes measurable objectives and timetables to meet a resident's needs as identified in the comprehensive assessment. 1. Corrective Action: Care plans for Resident A were reviewed and revised as appropriate, specifically addressing hydration needs. RD (Registered Dietician) reassessed resident and reviewed recommendations. Hydration needs have been added to the MAR (Medication Administration Record) for documentation/monitoring purposes. 2. Identifying Others: Resident care plans have been reviewed and updated to ensure</p>	01/23/2012			

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	<p>at the time of the record review.</p> <p>The resident had recently been readmitted to the facility from a local area hospital. Discharge diagnoses included hypernatremia.</p> <p>Review of the "Medical Nutrition Therapy Assessment," dated 12-16-11 indicated the resident required approximately 2725 c.c. of fluids per day.</p> <p>On 12-28-11 at 1:10 p.m., the resident's lunch tray was observed. The resident had 4 ounces of juice and, 8 ounces of a yellow liquid.</p> <p>During interview at this time, the Dietician indicated the resident's meal trays contained 40 ounces of fluids, and that would not meet the requirement of the 2725 c.c. of fluids needed per day.</p> <p>Further review of the resident's clinical record lacked a plan of care which provided interventions/system to ensure the resident hydration needs were met.</p> <p>3.1-35(a) 3.1-35(b)(2)</p>		<p>appropriate diagnosis/needs have been addressed. Nursing Assessments are completed upon admission, quarterly and with significant change and residents are specifically screened for dehydration risk at that time.3. Systematic Changes: New Admissions being discussed in the morning clinical meeting and care plans are developed to address special needs/diagnosis. Change of Condition forms are utilized, which include care plan updates to address new orders and/or condition changes. C.N.A. assignments sheets are updated accordingly. Nursing staff has been inserviced on Kindred policy and procedure related to care planning and hydration.4. Monitoring: RD will perform Hydration review weekly x4 weeks and then quarterly until substantial compliance is achieved. (Criteria in audit tool will be 100%) 5. Completion Date: 1-23-2012</p>		

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F0282 SS=D	<p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on observation, interview and record review, the facility failed to ensure a resident's plan of care was followed, in that when a resident was identified and assessed with requiring the assistance and supervision of the nursing staff for meal service, the nursing staff provided and set up a meal tray for the resident, and then left the resident unattended while eating for 1 of 3 resident' who required supervision during meals in a sample of 6. [Resident "A"].</p> <p>Findings include"</p> <p>The record for Resident "A" was reviewed on 12-27-11 at 11:50 a.m. Diagnoses included, but were not limited to, diabetes insipidus, seizure disorder, adrenal insufficiency and acute renal failure. The record also indicated the resident was blind. These diagnoses remained current at the time of the record review.</p> <p>Review of the resident's Minimum Data Set assessment, dated 11-16-11 indicated the resident required set up and supervision of one staff member for eating.</p>	F0282	<p>F 282It is the practice of this facility to provide services by qualified persons in accordance with each resident's written plan of care.1. Corrective Action: RD (Registered Dietician) reassessed Resident A and care plan was reviewed and updated as appropriate.2. Identifying Others: Those residents requiring assistance have had CNA assignment sheets/care plans reviewed and updated. 3.Systematic Changes: Nursing staff educated not to leave residents unattended who need supervision and/or assistance with meals. CNAs have been educated with regards to Resident A specific plan of care as well. 4. Monitoring: DNS/designee will audit nursing supervision of residents who require assistance/supervision during meals randomly x 4weeks; then monthly x3 or until substantial compliance is achieved. Results of the audits will be reviewed in PI monthly x3 or until substantial compliance is achieved (Criteria in audit tool will be 100%). 5. UM/DNS/RD/ED to ensure compliance by 1-23-2012.</p>	01/23/2012	

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F0323 SS=G	<p>However the "Medical Nutritional Therapy Review" dated 11-15-11 indicated the resident required "EA [Extensive Assist], with meals."</p> <p>The record indicated the resident received a regular no added salt diet and ate all three meals in the assist dining room.</p> <p>Review of the resident's current plan of care, dated 11-15-11, indicated "feed resident meals."</p> <p>A "Medical Nutrition Therapy Review" notation, dated 08-24-11 indicated the resident "must be fed."</p> <p>On 12-28-11 at 1:10 p.m., the resident was observed sitting up in bed, eating the noon meal without supervision. During an interview at this time, a CNA indicated the resident didn't want to get out of bed "all day so we gave [resident] the tray in room."</p> <p>3.1-35(g)(2)</p> <p>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 observation, record review and</p>	F0323	F 0323It is the practice of this	01/23/2012	

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	<p>interview, the facility failed to ensure the safety and supervision of a dependent resident, in that a resident who was assessed as dependent on staff and bedridden, was positioned onto the side of the bed and then left unattended which resulted in the resident falling to the floor and sustaining multiple fractures. [Resident "B"].</p> <p>In addition, the facility failed to ensure the supervision of a visually impaired resident during meal times, and also failed to supervise and implement safety strategies for a resident who had a recent intracranial bleed, with subsequent vision impairment. [Residents "A" and "C"].</p> <p>This deficient practice affected 3 of 6 sampled residents. [Resident's "A", "B" and "C"].</p> <p>Findings include:</p> <p>1.) The record for Resident "B" was reviewed on 12-27-11 at 1:50 p.m. Diagnoses included, but were not limited to, multiple sclerosis, depressive disorder, colostomy, urostomy, chronic pain and quadriplegia. These diagnoses remained current at the time of the record review.</p> <p>Review of the resident's Minimum Data Set summary dated 11-01-11, indicated</p>		<p>facility to ensure that the resident environment remains as free of accident hazards as possible; and each resident receives adequate supervision and assistance to prevent accidents. 1. Corrective Action: Residents A and C had care plans reviewed and revised to ensure visual impairments were addressed and assignment sheets were updated. Resident B has been discharged home at this time, however facility will submit internal plan of correction with regards to this fall: a.) Resident B was hospitalized for evaluation and treatment. Vital Signs and neurological checks were within normal limits at the time of the transfer. Investigation of the event has been completed. Bed was removed from operation until checked for any mechanical failure (none was found) and staff inserviced to ensure proper use. Notifications were made as appropriate. b.) Potential residents affected: Fall risk assessments were performed on residents by 12-19-2011 and residents at risk for falls have been identified and interventions reviewed to ensure appropriateness. Residents with air mattresses have been identified and settings reviewed for appropriateness. Settings been placed on the TAR (treatment record) to ensure they are checked every shift. Bed safety evaluations were also reviewed and updated.</p>		

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	<p>the resident required total assistance with transfers and bed mobility and the assistance of two staff members.</p> <p>The Care Area Assessment, dated 11-01-11, indicated the resident was dependent for all transfers and mobility secondary to multiple sclerosis.</p> <p>The resident's plan of care, dated 10-26-11, indicated the resident was "at risk for falls related to multiple sclerosis, decreased mobility, bilateral foot contractures, weakness and inability to ambulate."</p> <p>Review of the "Physical Therapy Evaluation," dated 10-26-11, indicated the resident had "B [circled - bilateral]" foot contractures, confusion, "coordination impairment with poor safty &lt;sic&gt; awareness secondary to bedridden and cognition with maximum assistance with bed mobility."</p> <p>The Resident Progress note, dated 12-14-11, indicated the following incident with injury to the resident. "2:15 p.m. - Staff notified nurse that drsg. [dressing] to patient's bottom was soiled with urine and patient care was needed. Staff stuck her head out of the patient's room to notify nurse she was ready for the dsrg. to be changed and that the patient</p>		<p>Residents identified as fall risks will be identified with a "falling star" outside of their room, identified on the C.N.A assignment sheets, which will also be shared with the Angel Care champion assigned to the specific resident (these are department leaders who have been inserviced and assigned a specific resident group.). Care plans have been reviewed and updated for all patients identified "at risk" and interventions are updated after each fall. DNS met with nursing staff on 12-16-11, 12-17-11; ED on 12-18-11 to ensure staff answers lights in a timely manner, checked alarms for positioning and proper placement, and that interventions are in place to protect residents. Education is on going with regards to turning, positioning, and the use of specialty mattress.</p> <p>c) Systematic Changes: Newly admitted residents identified as "at risk" for falls will be reviewed in the daily clinical meeting and interventions put in place immediately. Residents will have fall assessments done quarterly thereafter and/or with any significant change. Care plan interventions will be updated as appropriate to ensure safety. Per IDT recommendations, falling star at doorway to identify the resident, Angel Care participants will also have a C.N.A assignment sheet to validate interventions are in place. Care</p>				

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	<p>was laying flat in &lt;sic&gt; her stomach with her bottom up. When staff turned around, she screamed 'Oh my God, she's on the floor.' Nurses ran to the room. When entering the room found resident on the floor between bed and wall with pillow under her head. Bed was rolled away from pt. [patient] for assessment. Pt was laying on her right side. Able to verbalize no pain. Pt. was crying, stated 'I'm sorry I'm so sorry, please don't be mad at me.' Reassured pt. everything was okay nobody is mad. She stated, 'Is the girl mad at me? Tell her I'm sorry. Please don't be mad.' While staying by pt. side, this writer completed assessment and noted her left hip had an abnormal body alignment. Second nurse left room to obtain dynamap [a device to measure the resident's blood pressure and pulse], and assigned nurse &lt;sic&gt;. When nurses returned to room obtained vitals [vital signs]. Log rolled pt. onto a sheet, made as comfortable as possible."</p> <p>A subsequent nurses notation on 12-14-11 at 2:45 p.m. indicated the following: "Was called to res. room at 2:20 p.m. by nursing staff. Found res. on floor. Res. a &amp; o [alert and oriented] times 3. Neuro [neurological checks] WNL [within normal limits] Res. stated 'I shifted my wt. [weight] and slid out of the bed. I'm sorry.' Res. c/o [complained of] left hip</p>		<p>plans have been reviewed and updated as appropriate and interventions have been identified and implemented. Staff has been inserviced by DNS/ED on 12-16, 17 and 18-2011 with regards to answering call lights timely, bed placement and the fall program. Nursing staff have been inserviced by the wound nurse and bed representative on 12-19-2011 regarding the proper use of the specialty mattress, settings documented and system of monitoring implemented (with wound nurses responsible). Air mattresses will be "locked" in appropriate settings for weight and identified at the foot of the bed. SDC educated staff on Falls Management program on 12-15, 12-19-2011 and 1-6-2012. DNS/ED review of residents who have fallen in last 90 days to ensure appropriate interventions are in place and effective. (Completed 12-19-2011). Any new admission, being identified at risk (45 or higher) will have interventions put into place immediately and reviewed in the morning clinical meeting.d.) Monitoring- DNS directed nursing staff to frequently monitor their residents at risk for falls. UM/DNS/ED/designee will round to ensure call lights are answered timely, and that interventions are in place and effective. DNS/ED will use review of process measure for the management of the fall program to use as a guide</p>		

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	<p>and right shoulder pain. Left leg externally rotated no discoloration or open areas noted. Res. cried out in pain to touch. Made comfortable on floor r/t [related to] resident request to not be moved. Res. state she hit her head on the trash can next to bedside. Examined head. No note &lt;sic&gt; s/s [signs of symptoms] of injury/dyscoloration."</p> <p>A nurses progress note dated 12-15-11 at 10:00 a.m. indicated the nurse "call &lt;sic&gt; hospital to obtain &lt;sic&gt; status of res. Nurse reported "B" [circled - bilateral] pelvis fx. [fracture] with multiple fx."</p> <p>During interview on 12-27-11 at 2:20 p.m., Licensed Practical Nurse Employee #3 indicated, "I was at the desk at the nurses station, charting, when the aide [in reference to Certified Nurses Aide employee #11] asked if someone could do a dressing change. The nurse assigned to [resident] was not available. I checked the orders and the I heard her [CNA employee #11] scream 'Oh my God she's on the floor.' [Name of Licensed Practical Nurse employee #6] was also at the nurses station. We went into the room. she [in reference to the resident] was on the floor under the register. I had to let the bed out all the way because I couldn't get to her, the bed was really close to the wall - she fell out the side by the windows. The</p>		<p>for Performance Improvement. CQR (Kindred audit) will be done on falls and reported to PI committee monthly in summary. Fall management is an ongoing agenda item monthly of the committee. e.) Completion date of this POC: 12-19-2011. 2. Identifying Others: Those residents with visual impairments have had care plans reviewed and updated as appropriate. Newly admitted residents identified as "at risk" for falls will be reviewed in the daily clinical meeting and interventions put in place immediately. Residents will have fall assessments done quarterly thereafter and/or with any significant change. Care plan interventions will be updated as appropriate to ensure safety. falling star at doorway to identify the resident per Kindred policy, Angel Care participants will also have a C.N.A assignment sheet to validate interventions are in place.3. Systematic Changes: See 1 c). DNS/ED/SDC inserviced policy on turning and positioning, care of the injured resident and accidents on 12-15, 17, 18, 19; 1-7, 9; 1-16, 1-21.4. Monitoring: UM/RD/DNS/ED rounds during mealtimes to ensure adequate assistance/supervision. UM/DNS/ED and department managers rounding randomly throughout the day to ensure safe environment for our residents. Review of events (falls) in clinical</p>		

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	<p>height of the bed was about 3 feet from the floor. The top siderails were up and she was laying on the right side on the floor. Her left hip was in funny alignment and her leg was across her body. I didn't move her. We tilted her a little bit and put a sheet under her. When she slid out of bed her pillow went with her and it was partially under her head."</p> <p>During interview on 12-28-11 at 9:30 a.m., Licensed Practical Nurse employee #6 indicated "I was at the desk and so was [name of Licensed Practical Nurse employee #3] when the CNA came to the door and said she needed a nurse to change the dressing. The next thing she yelled 'Oh my God, she's on the floor.' [Name of resident] fell off the bed. I went to the room, and I couldn't believe the little space between the wall and the bed and she was between the little space on the floor, and her legs were in a weird position." The nurse demonstrated a space between the bed and the wall of approximately 1 foot.</p> <p>During interview on 12-29-11 at 9:10 a.m., Licensed Practical Nurse employee #5 [wound care nurse] indicated "[Name of resident] is flaccid on the left side. When I did the dressing change I usually placed her on the right side so she couldn't move. It was safer. If she was laying in</p>		<p>meeting with interventions implemented and evaluated for effectiveness. DNS/designee will audit using Kindred CQR tool, falls weekly x4; then monthly x 3 or until substantial compliance is achieved. Audits will be reviewed monthly x 3 or until substantial compliance is achieved (Criteria in audit tool will be 100%). 5. Completion Date: 1-23-2012.</p>		

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	<p>bed on her back, it looked like her legs went straight down, until her knees where they seemed to go out away from the center and then her ankles were contracted."</p> <p>During interview on 12-29-11 at 9:20 a.m. Licensed Practical Nurse employee #10 indicated, "I changed her urostomy that day and she was saturated with urine. I told the CNA [employee #11] she need to be cleaned up. I know if she [in reference to the resident] was holding onto the side rail she couldn't do it for very long because she could spontaneously let go and not realize it. She might be able to reposition her shoulders but not her legs. When she was on the floor I put another pillow under her head. There was already a sheet under her when I got to the room and I put a sheet over her because she was exposed. When I first went into the room I thought she was dead."</p> <p>Interview on 12-29-11 at 10:10 a.m. with the Physical Therapist employee #8, who was identified by the Director of Nursing services as the therapist who worked with the resident, indicated the following: "She couldn't be positioned on her side safely. The only thing she could really move is her neck. She was usually positioned on her back."</p>				

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	<p>During interview on 12-27-11 at 10:00 a.m., the Executive Director indicated she spoke with the resident who indicated to her that the CNA positioned her too close to the edge of the bed, "so close that her nose touched the side rail. She left the resident unattended and the resident fell from the bed onto the floor."</p> <p>During an observation on 12-27-11 at 3:00 p.m., with the Executive Director in attendance, the resident's room, bed placement and the register were observed. The register spanned the entire length of the wall.</p> <p>Review of the Hospital "Radiology Result," dated 12-14-11 indicated, "Fell out of bed at rehabilitation center." "Impression: 1. Acute nondisplaced obliquely oriented fracture through the proximal diaphysis of the left femur, 2. Acute fracture through the left superior pubic ramus. An acute fracture of the right acetabulum and probable acute nondisplaced fracture of the right inferior pubic ramus, 3. Acute comminuted fracture through the proximal diaphysis of the right femur, 4. Acute nondisplaced fracture through the distal diaphysis of the left femur, 5. Age interminate buckle fracture through the distal right femoral</p>						

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	<p>metaphysis."</p> <p>Review of facility policy on 12-28-11 at 9:50 a.m., titled "Care of a Patient with Possible Injury", and dated 04-28-11, indicated the following:</p> <p>"Rationale: A patient involved in an incident where injury can be reasonable suspected is assessed and emergency care given as needed."</p> <p>"Procedure: 1.) Call for assistance. a.) Do not move the patients. b.) Do not place anything under the head.</p> <p>2.) The record for Resident "A" was reviewed on 12-27-11 at 11:50 a.m. Diagnoses included, but were not limited to, diabetes insipidus, seizure disorder, adrenal insufficiency and acute renal failure. The record also indicated the resident was blind. These diagnoses remained current at the time of the record review.</p> <p>Review of the resident's Minimum Data Set assessment, dated 11-16-11 indicated the resident required set up and supervision of one staff member for eating.</p> <p>The record indicated the resident received a regular no added salt diet and ate all</p>				

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	<p>three meals in the assist dining room.</p> <p>Review of the resident's current plan of care, dated 11-15-11, indicated "feed resident meals."</p> <p>A "Medical Nutrition Therapy Review" notation, dated 08-24-11 indicated the resident "must be fed."</p> <p>On 12-28-11 at 1:10 p.m., the resident was observed sitting up in bed, eating the noon meal without supervision. During an interview, a CNA indicated the resident didn't want to get out of bed "all day so we gave [resident] the tray in room."</p> <p>3.) The record for Resident "C" was reviewed on 12-28-11 at 10:30 a.m. Diagnoses included, but were not limited to, acute intracranial bleed, hypertension, recent craniotomy and right hemiparesis. These diagnoses remained current at the time of the record review.</p> <p>During an interview on 12-28-11 at 11:00 a.m., the resident indicated recent hospitalization and [pointing to the left side of head], craniotomy. During the interview, the resident struggled to speak, but the resident was able to indicate the lack of peripheral vision with the right eye. The resident continued to explain,</p>				

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F0327 SS=D	<p>the peripheral vision with the left eye remained intact, but had increased difficulty with the right eye. The resident indicated he left the blinds to the window in his room, "up," because he had hoped something, a movement, might "catch" his eye, and the peripheral vision would return.</p> <p>Review of the resident progress notes, dated 12-12-12 at 4:00 p.m., indicated "Res. [resident] states unable to see out of the 'sides of eyes together' when focusing on an object. Able to see peripherally when one eye covered."</p> <p>Although the record contained information in the progress notes related to the resident's lack of peripheral vision, the facility failed to provide supervision or assistive devices to aide the resident or prevent the potential of an accident.</p> <p>This Federal deficiency relates to Complaint IN00101278.</p> <p>3.1-45(a)(2)</p> <p>The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health. Based on observation, interview and record review, the facility failed to ensure</p>	F0327	F327It is the practice of this facility to provide each resident with sufficient fluid intake to	01/23/2012	

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	<p>a resident's hydration needs were met, in that when a resident had specific hydration needs related to a diagnosis of diabetes insipidus and hypernatremia, the facility failed to ensure the hydration needs were met for 1 of 2 residents with hydration needs in a sample of 6. [Resident "A"].</p> <p>Findings include:</p> <p>The record for Resident "A" was reviewed on 12-27-11 at 11:50 a.m. Diagnoses included, but were not limited to, diabetes insipidus, seizure disorder, adrenal insufficiency and acute renal failure. The record also indicated the resident was blind. These diagnoses remained current at the time of the record review.</p> <p>The resident had recently been readmitted to the facility from a local area hospital. Discharge diagnoses included hypernatremia (high sodium level).</p> <p>Review of the "Medical Nutrition Therapy Assessment," dated 12-16-11, indicated the resident required approximately 2725 c.c. of fluids per day.</p> <p>On 12-28-11 at 1:10 p.m., the resident's lunch tray was observed. The resident had 4 ounces of juice and, 8 ounces of a yellow liquid.</p>		<p>maintain proper hydration and health.1. Corrective Action: The care plan for Resident A has been reviewed and updated. RD has reassessed resident fluid need, has updated progress note, recommendations. 2. Identifying Others: Nursing assessments are done for residents upon admission, quarterly and with any significant change to address Risk factors and to screen residents for dehydration. Care plans are developed based upon risks as identified by the comprehensive assessment.3. Systemic Changes: Care plans on new admissions and with significant changes related to hydration are developed following chart review in the daily clinical meeting and areas "at risk" addressed. 4. Monitoring: RD will perform hydration review weekly x4, monthly x3 and then quarterly x2 or until substantial compliance is achieved. Audits will be reviewed during PI monthly X3 or until substantial compliance achieved (Criteria in audit tool will be 100%).5. RD/DNS/ED to ensure compliance by 1-23-2012.</p>				

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	<p>During interview on 12-28-11 at 2:00 p.m., the Dietician indicated the resident's meal trays contained 40 ounces of fluids, and that would not meet the requirement of the 2725 c.c. of fluids needed per day.</p> <p>3.1-46(b)</p>				