

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155496	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/27/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER KINDRED NURSING AND REHABILITATION VALLEY VIEW	STREET ADDRESS, CITY, STATE, ZIP CODE 333 W MISHAWAKA RD ELKHART, IN 46517
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	<p>This visit was for the Investigation of Complaint IN00115627.</p> <p>Complaint IN00115627-Substantiated. Federal/state deficiencies related to the allegations are cited at F157 and F323.</p> <p>Survey dates: September 26, 27, 2012</p> <p>Facility number: 000523 Provider number: 155496 AIM number: 100266930</p> <p>Survey team: Ann Armey, RN</p> <p>Census bed type: SNF/NF: 88 Total: 88</p> <p>Census payor type: Medicare: 7 Medicaid: 65 Other: 16 Total: 88</p> <p>Sample: 4</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed 9/28/12 Cathy Emswiller RN</p>	F0000	<p>This Plan of Correction is the center's credible allegation of compliancePreparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155496		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/27/2012	
NAME OF PROVIDER OR SUPPLIER KINDRED NURSING AND REHABILITATION VALLEY VIEW				STREET ADDRESS, CITY, STATE, ZIP CODE 333 W MISHAWAKA RD ELKHART, IN 46517			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
F0157 SS=D	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) 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 observation, interview and record review, the facility failed to notify the physician when a resident refused treatments. This deficiency affected 1 of 3 residents, whose treatments were</p>	F0157	F 1571. Resident # D has been reassessed for pressure area interventions with her plan of care updated as needed. Her physician has been advised and consulted as well. 2. The Director	10/27/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155496		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/27/2012	
NAME OF PROVIDER OR SUPPLIER KINDRED NURSING AND REHABILITATION VALLEY VIEW				STREET ADDRESS, CITY, STATE, ZIP CODE 333 W MISHAWAKA RD ELKHART, IN 46517			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>reviewed, in a sample of 4. (Resident #D)</p> <p>Findings include:</p> <p>On 9/26/12 at 9:10 a.m., during the orientation tour, LPN #10, indicated Resident #D had a stage I pressure ulcer on her coccyx. The resident was observed sitting in a wheelchair in her room with a pressure relieving cushion in her wheelchair.</p> <p>The clinical record of Resident #D was reviewed on 9/26/12 at 10:45 a.m. The care plan for Skin at Risk, initiated on 2/7/12 and dated as revised on 8/2012, indicated, in part; Follow Medical Doctor orders for skin care and treatments.</p> <p>Physician orders, dated 8/14/12, indicated change Comfeel (a hydrocolloid wound dressing) to coccyx every 72 hours and as needed.</p> <p>The Weekly Skin Check Sheet, dated 9/12/12 and 9/19/12, indicated Resident D's "bottom red."</p> <p>An initial Weekly Pressure Ulcer Report, dated 9/26/12, indicated Resident #D had a Stage I ("Non-blanchable erythema") pressure area on her sacral/coccyx area</p>		<p>of Nursing or designee will review resident records for any other residents refusing treatment which require physician notification to ensure proper physician notification has occurred. 3. The Staff Development Coordinator or designee will in-service licensed nurses on the Kindred policy and procedures related to physician notification for resident refusal of treatment. The Staff Development Coordinator or designee will review the Physician Notification policy and procedure with appropriate new hires during orientation. 4. The interdisciplinary team will review all incidents and accidents on the next scheduled day of service to ensure appropriate physician notification has taken place. The Director of Nursing or designee will monitor through 5 observations per week and assure any required physician notification has taken place when resident refusal of treatment has taken place. The results of these audits will be reviewed and analyzed with a subsequent plan of action developed and implemented as indicated at</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155496		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/27/2012	
NAME OF PROVIDER OR SUPPLIER KINDRED NURSING AND REHABILITATION VALLEY VIEW				STREET ADDRESS, CITY, STATE, ZIP CODE 333 W MISHAWAKA RD ELKHART, IN 46517			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>measuring 7.0 cm by 7.0 cm.</p> <p>The September 2012 TAR (Treatment Administration Record) indicated Resident #D had refused the Comfeel Dressing on 7 of 9 scheduled days, including; 9/2/12, 9/5/12, 9/8/12, 9/11/12, 9/14/12, 9/23/12, and 9/26/12.</p> <p>Although the resident coccyx was red, there was no documentation the physician was notified or consulted about an alternate treatment, when she continued to refuse the Comfeel Dressing.</p> <p>On 9/26/12 at 2:10 p.m., Resident #D was interviewed. She indicated her bottom was very sore and she would not refuse the patch or anything that would make her more comfortable.</p> <p>On 9/27/12 at 1:30 p.m., the DON (Director of Nursing) was interviewed. The DON indicated the physician had been notified, on 8/27/12, that the resident refused the Comfeel Dressing because the area felt better.</p> <p>The DON indicated there was no documentation the physician was notified or consulted about an alternate treatment, in September 2012, when the resident continued to refuse the Comfeel Dressing and when her coccyx was noted to be red.</p>		<p>the monthly Performance Improvement Committee Meeting. The PI Committee will review monthly for 6 months. The Administrator is responsible for overall compliance.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155496	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/27/2012
NAME OF PROVIDER OR SUPPLIER KINDRED NURSING AND REHABILITATION VALLEY VIEW			STREET ADDRESS, CITY, STATE, ZIP CODE 333 W MISHAWAKA RD ELKHART, IN 46517		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>On 9/27/12, An order was obtained which indicated Xenaderm was to be applied to the resident's reddened coccyx three times daily.</p> <p>On 9/27/12 at 3:00 p.m., accompanied by LPN #11, the area on Resident #D's coccyx was observed. The area was red in the fold of the buttock. No open areas were observed. LPN #11 indicated a barrier cream had been applied to the area on the coccyx because the Xenaderm had not been delivered from the pharmacy.</p> <p>The Policy for Resident Refusal of Treatment, dated 4/28/10, provided by the DON, indicated; "The resident has the right to refuse treatment.. 6. Center staff should:.. c. Offer alternative treatments,.. 7. Notify the Physician and consult for any alternative treatment and document in the resident's medical record..."</p> <p>This Federal tag relates to Complaint IN00115627.</p> <p>3.1-5(a)(3)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155496		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/27/2012	
NAME OF PROVIDER OR SUPPLIER KINDRED NURSING AND REHABILITATION VALLEY VIEW				STREET ADDRESS, CITY, STATE, ZIP CODE 333 W MISHAWAKA RD ELKHART, IN 46517			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
F0323 SS=G	<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 provide adequate supervision to prevent a fall, which resulted in a fracture. This deficiency affected 1 of 3 residents, who were reviewed for falls, in a sample of 4. (Resident #D)</p> <p>Findings include:</p> <p>On 9/26/12 at 9:10 a.m., during the orientation tour, LPN #10, indicated Resident #D had a recent fall with a fracture. The resident was observed sitting in a wheelchair in her room with a sling on her left arm.</p> <p>The clinical record of Resident #D was reviewed on 9/26/12 at 10:45 a.m.</p> <p>The MDS (Minimum Data Set) Assessment, dated 9/10/12, indicated the resident had moderate cognitive impairments and was not steady when turning or walking. The MDS indicated the resident required limited assistance of</p>	F0323	F3231. Resident # D has been reassessed for fall prevention interventions with her plan of care updated as needed. 2. The Director of Nursing or designee will review the plan of care and recommended interventions along with staff awareness and compliance with implementation of interventions for residents deemed at risk for falls and initiate corrective action as indicated. In addition the Director of Nursing or designee will reassess and review the plan of care for residents using power chairs, and care plans will be updated as appropriate. 3. The Staff Development Coordinator or designee has in-serviced staff on the Kindred policy and procedures related to the fall prevention program. In-services included following interventions to prevent falls, not leaving residents unattended in shower rooms and not taking motorized wheelchairs into shower rooms. The Staff Development Coordinator or	10/27/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155496	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/27/2012
NAME OF PROVIDER OR SUPPLIER KINDRED NURSING AND REHABILITATION VALLEY VIEW			STREET ADDRESS, CITY, STATE, ZIP CODE 333 W MISHAWAKA RD ELKHART, IN 46517		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>one staff person for bathing.</p> <p>Nursing notes indicated the following: On 9/15/12 at 10:30 a.m., "Resident was in shower room awaiting shower. She stated she was trying to get up to weigh herself and the chair moved backward & (and) she went forward. She said her chair went crazy and tried to run her over..." The note indicated the resident complained of pain in the left shoulder and left hip. The note further indicated an x-ray was to be obtained. On 9/15/12 at 2:30 p.m. "X-ray results arrived. L (left) hip is normal. L (left) shoulder is fractured at the humerus..." The note indicated the physician was notified and the resident was sent to the emergency room for evaluation. On 9/15/12 at 9:30 p.m., the resident returned from the hospital with orders for pain medication, ice to the injury and not to remove the splint on the left shoulder.</p> <p>The Emergency Room Report, dated 9/15/12, indicated the resident had sustained an acute closed fracture of the left humeral head.</p> <p>The care plan, initiated on 2/7/12 and dated as revised on 8/2012, indicated Resident #D was at risk for fall related injuries. Interventions, added on 9/17/12,</p>		<p>designee will review the Fall Prevention Program with appropriate new hires during orientation. 4. The interdisciplinary team will review all incidents and accidents on the next scheduled day of service to ensure appropriate plan of care and interventions have been implemented and are in place. The Director of Nursing or designee will monitor through 5 observations per week during clinical meetings, and review fall prevention care plans and assure interventions are in place to ensure and maintain compliance. The results of these audits will be reviewed and analyzed with a subsequent plan of action developed and implemented as indicated at the monthly Performance Improvement Committee Meeting. The PI Committee will review monthly for 6 months. The Administrator is responsible for overall compliance.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155496	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/27/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER KINDRED NURSING AND REHABILITATION VALLEY VIEW	STREET ADDRESS, CITY, STATE, ZIP CODE 333 W MISHAWAKA RD ELKHART, IN 46517
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>indicated, the following: Do not leave unattended in shower room, Quarterly PT(Physical Therapy)/OT(Occupational Therapy) screen for motorized wheelchair safety, and Do not take motorized wheelchair into the shower room.</p> <p>The "Alleged Abuse, Neglect and Exploitation Investigation" Worksheet, signed by the Administrator on 9/24/12, indicated the resident was taken into the shower room in her motorized wheelchair. The aide left Resident #D unattended briefly while she went to get a towel or bath blanket. When the aide returned to the shower room, Resident #D was on the floor.</p> <p>The Summary Report of Findings indicated "Resident should not have been transported to shower room in motorized wheel chair and should not have been left unattended. This staff member,....,has been terminated."</p> <p>On 9/26/12 at 12 noon, the DON (Director of Nursing) was interviewed. The DON indicated the aide assignment sheet, prior to the fall, directed that the resident was not to be left unattended in the shower room. The DON indicated she did not have a written policy regarding supervision in the shower room but the</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155496	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/27/2012
NAME OF PROVIDER OR SUPPLIER KINDRED NURSING AND REHABILITATION VALLEY VIEW			STREET ADDRESS, CITY, STATE, ZIP CODE 333 W MISHAWAKA RD ELKHART, IN 46517		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>facility had an unwritten policy that residents were not to be left unattended in the shower room.</p> <p>This finding relates to Complaint IN00115627.</p> <p>3.1-45(a)(2)</p>				