

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155336	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/08/2012
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NAME OF PROVIDER OR SUPPLIER  DECATUR TOWNSHIP CARE AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 4851 TINCHER RD INDIANAPOLIS, IN 46221
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F0000	<p>This visit was for the Investigation of Complaint IN00108836 and Complaint IN00109028.</p> <p>Complaint IN00108836 substantiated, no deficiencies related to the allegation are cited.</p> <p>Complaint IN00109028 substantiated, federal/state deficiencies related to the allegations are cited at F221.</p> <p>Survey dates: June 7 &amp; 8, 2012</p> <p>Facility number: 000229 Provider number: 155336 AIM number: 100266850</p> <p>Survey team: Joyce Hofmann, RN, TC Barbara Hughes, RN</p> <p>Census bed type: SNF/NF: 74 Total: 74</p> <p>Census payor type: Medicare: 6 Medicaid: 51 Other: 17 Total: 74</p>	F0000	<p>The Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Decatur Care &amp; Rehabilitation Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency. Decatur Township Care &amp; Rehabilitation Center is requesting a paper compliance review of this survey.</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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	<p>Sample: 4</p> <p>This deficiency also reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed 6/13/12 Cathy Emswiller RN</p>			

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F0221 SS=D	<p>483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS</p> <p>The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.</p> <p>Based on record review and interviews the facility failed to maintain the highest well being of Resident #A and control his behavior without the use of a gait belt (restraint) while sitting in his wheelchair.</p> <p>Findings include:</p> <p>Review of nursing notes on 6/7/12 at 3:45 p.m. indicate that on 5/21/12 Resident #A became restless exhibiting inappropriate behaviors of hitting and cursing. On 5/22/12 at 12:00 a.m. his physician was notified and an IM injection of Ativan was ordered. During the evening shift (1:00 to 10:00 p.m.) this resident attempted to slide out of his wheelchair several times.</p> <p>A verbal statement (documented) from LPN #A to the DON on 5/23/12 at 2:p.m. indicated that on 5/22/12 at 9:30 p.m. LPN #A placed a gait belt around Resident #A and his chair to help him with positioning and keep him from sliding down. The DON indicated that she re-educated LPN #A indicating a gait belt was not to be used as a positioning</p>	F0221	<p>A. The residents had the potential to be affected by misuse of physical restraints. Resident A no longer resides in the facility. No adverse effects were noted.</p> <p>B. An immediate audit was done to identify any other possible physical restraints for potentially affected residents. No other residents were affected.</p> <p>C. The facility nursing staff will be reeducated by ADON/Designee by 6/19/12 on proper use of physical restraints.</p> <p>D. A weekly audit will be done by the DNS/Designee for 5 weeks to monitor for use of physical restraints, then monthly for 3 months or until 95% of physical restraints are documented. The audits will be reviewed in the next monthly Performance Improvement meeting by the Administrator for any further recommendations.</p>	06/19/2012			

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	<p>device.</p> <p>The Resident's care plan for dated 3/23/12 for agitation and combativeness indicated Ativan prn was to be used as an intervention per order. Nursing notes on 5/22/12 at 9:30 P.M. indicate the resident refused all meds. A care plan for falls indicated anti rollbacks were placed on 5/11/12 and an alarm sensor pad was placed in the wheelchair on 5/19/12.</p> <p>An interview with CNA #A on 6/7/12 at 4:25 p.m. indicated that she assisted Resident #A with 1:1 assistance on 5/22/12 all day making sure he was not hitting other residents and getting out of his chair but during the end of the shift a gait belt was used to help him with repositioning. She indicated he slid out of his chair in an assisted fall and that Resident #A was confused and agitated.</p> <p>A review of facility policy on 6/7/12 at 5:45 indicated that "physical restraints" are defined as physical device, adjacent to the resident's body that restricts freedom of movement to one's body and include soft ties.</p> <p>3.1-3(w)</p>						

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