

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155132	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/08/2011
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NAME OF PROVIDER OR SUPPLIER DANVILLE REGIONAL REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 255 MEADOW DR DANVILLE, IN46122
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F0000	<p>This visit was for Investigation of Complaints IN00097214 and IN00097456.</p> <p>This visit was in conjunction with the Post Survey Revisit (PSR) to the Investigation of Complaint IN00094797 completed on August 19, 2011.</p> <p>This visit was also in conjunction with the PSR to the Investigation of Complaint IN00095233 completed on August 31, 2011.</p> <p>Complaint IN00097214 - Substantiated. Federal/State deficiencies related to the allegations are cited at F241.</p> <p>Complaint IN00097456 - Substantiated. No deficiencies related to the allegations are cited.</p> <p>Survey dates: October 4-8, 2011</p> <p>Facility number: 000057 Provider number: 155132 AIM number: 100266570</p> <p>Survey team: Vanda Phelps, RN</p> <p>Census bed type: 24 SNF</p>	F0000		

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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F0241 SS=E	<p>86 SNF/NF 110 Total</p> <p>Census payor type: 26 Medicare 72 Medicaid 12 Other 110 Total</p> <p>Sample: 9</p> <p>This deficiency also reflects state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed 10/17/11 by Jennie Bartelt, RN.</p> <p>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.</p> <p>Based on observation, record review and interviews, the facility failed to consistently uphold the dignity of 4 of 5 residents reviewed regarding basic care</p>	F0241	Corrective Action: The schedule to change bed linen has been reviewed – policy and procedure will be followed as indicated. Other Residents	11/07/2011	

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	<p>needs not met on the ALT-U wing in the total sample of 9. This was in regard to the failure to ensure bed linens were consistently changed as needed and call lights not consistently answered timely. (Residents J, L, M and P)</p> <p>Findings include:</p> <p>1. Confidential interview of the family of Resident M during this survey indicated they had been quite angry over the staff's failure to change the bed linens when they were soiled with food stains. They indicated they had seen the same food stains on the linens 3-4 days straight and had to demand someone change the linens to get it done. They said this had occurred 2-3 times so far in this admission and they felt it was indicative of a lack of staffing. "The ones who are here are very busy, you never see them lolling around, but there just aren't enough of them...We shouldn't have to tell them the sheets need changed. That goes with the job." They indicated call light response was slow, taking 15 minutes on the average and sometimes longer. The family member indicated Resident M had been "reduced to yelling for help from the bathroom when no one answered the call light." The family indicated Resident M had been very upset about having to "yell like a beggar" before staff came to assist.</p>		<p>Having Potential to be Affected: Administrator/Guest Relations will conduct weekly interviews with all residents on ALTU, specifically addressing timeliness of call lights being answered and bed linen changes to ensure call lights are being answered in a timely manner and bed linens are being changed no less than 2x/week or as needed or requested. Systematic Changes: A resident right in-service for all staff will be completed with specifics as it relates to call lights and bed linen changes. The Administrator will conduct bi-monthly meetings with residents on ALTU to ensure resident needs are being addressed, such as timeliness of call lights and bed linen changes. The Unit Manager/designee will verify bed linens have been changed on shower days. Guest Relations will address linen changes during daily rounds (5 days/week). Monitoring: The Administrator, DON and staffing coordinator will meet weekly to discuss staffing levels for the building. No less than bi-weekly new employee orientation will be in effect in order to develop staffing levels in conjunction with census development. Administrator will monitor timeliness of call lights being answered and bed linen changes through bi-weekly meetings with ALTU residents. Any concerns noted will be brought through</p>		

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	<p>The family also indicated they were concerned that if the "little" things weren't being tended to, what about the bigger things. They were looking for another facility to move Resident M.</p> <p>2. Resident L was identified by LPN #5 during the orientation tour as interviewable. Confidential interview of Resident L during this survey indicated they liked the ALT-U wing, but there were problems. Resident L stated, "If they're going to admit people, they ought to have enough staff first." This resident also had experienced problems having the bed linens changed when needed. On two occasions they had found it necessary to ask staff to change them because it had been 4-5 days and they were dirty. "That should be automatic."</p> <p>3. The family of Resident P indicated in interview 9/21/11 that they had visited the afternoon of 9/17/11 and found the resident in a "grimy" bed. When they asked staff to change the sheets, staff gave them clean sheets and told them to change the bed themselves as the staff was very busy. They indicated it took 20-30 minutes to get the call light answered. They indicated they moved the resident to another facility due to this.</p> <p>4. Review 10/4/11 at 2:20 p.m. of the</p>		monthly QA on an ongoing basis. Date of completion: 11-7-11		

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	<p>staffing pattern provided for survey review on 10/4/11 indicated the facility staffed the ALT-U wing as follows:</p> <p>day shift: 1 unit manager (RN) 1 nurse 1 concierge (also a nurse) 1-2 nurse aides</p> <p>afternoon/evening shift: 1-2 nurse 1-2 nurse aides</p> <p>night shift: 1 nurse 1 nurse aide</p> <p>Review of the staffing records for Saturday, 9/17/11, indicated the ALT-U wing was staffed as follows:</p> <p>day shift: 1 RN 1 LPN 1 nurse aide 1 LPN working as an aide</p> <p>afternoon/evening shift 2 LPNs 1 nurse aide</p> <p>night shift: 1 LPN 1 nurse aide</p>			

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	<p>On Sunday, 9/18/11, the ALT-U staffing was one nurse and one nurse aide on each of the three shifts. The census that weekend was 18 residents.</p> <p>On the weekend of 9/24 and 9/25/11, the census was at 21 residents. Staffing on both days was one nurse and one nurse aide on each of the three shifts.</p> <p>During this investigation of 10/4 through 10/8/11, the ALT-U wing resident census was at 24. But the staff on duty for the 2/10 shift remained at one nurse and one nurse aide.</p> <p>5. During the course of this investigation, October 4 through 8, 2011, 15 nursing staff (#1, 2, 3, 4, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15 and 16) were interviewed confidentially. Each expressed fear of losing their job if management heard what they had said. 14 of the 15 indicated they needed more help, especially at the nurse aide level. They indicated they were sometimes unable to do basic care such as showers, bed changes and residents complained fairly often of slow call light response. Each indicated they were doing the best they could, but there needed to be more nurse aides on duty.</p> <p>6. Resident J was identified during the orientation tour as interviewable. This</p>				

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	<p>resident spontaneously approached, and in a low voice, advised a weekend visit, because "'They' keep it good while you're here, but the weekends can be 'h---.'" The resident indicated the reference was to low staffing.</p> <p>On Friday afternoon, 10/7/2011, observation at 4:10 p.m. indicated there was one nurse and one nurse aide on duty on the ALT-U wing. Review of the staffing schedule for 10/7/11 on 10/6/11 at 3 p.m. indicated one nurse and one nurse aide was what had been scheduled for 10/7/11.</p> <p>Interview with the Director of Nursing on 10/7/11 at 12:10 p.m. indicated the ALT-U wing had been at capacity (24 residents) for about two weeks. Interview with the Administrator 10/7/11 at 4:35 p.m. indicated they were doing the best they could with staffing. She indicated they had a class of five nurses and/or nurse aides in orientation this week and plans for another soon. She also indicated the residents on the ALT-U wing were mostly alert and oriented and were in a rehab mode so didn't need as much hands-on care as the more dependent long term care residents. The issue of one nurse and one nurse aide being inadequate staffing was discussed.</p>				

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	<p>A weekend visit was conducted on Saturday 10/8/11 between 4 p.m. and 6 p.m. Again, there was one nurse and one nurse aide on duty in the ALT-U wing. The Administrator was in her office at 4 p.m. but went to the ALT-U wing immediately and assisted taking residents to the dining room for the evening meal. During the exit meeting on 10/8/11 at 5:55 p.m., she indicated there was enough staffing to meet the needs of the residents.</p> <p>This federal tag relates to Complaint IN00097214.</p> <p>3.1-3(t)</p>				