

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 06/27/2016
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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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F 0000 Bldg. 00	<p>This visit was for a Post Survey Revisit (PSR) to the Recertification and State Licensure Survey and the PSR to the Investigation of Complaints IN00198809 & IN00198879 completed on 5/12/16.</p> <p>Complaint IN00198809-Corrected</p> <p>Complaint IN00198879-Corrected</p> <p>Survey date: June 27, 2016</p> <p>Facility number: 000273 Provider number: 15A011 AIM number: 100267870</p> <p>Census bed type: NF: 123 Total: 123</p> <p>Census payor type: Medicaid: 122 Other: 1 Total: 123</p> <p>This deficiency reflects State findings cited in accordance with 410 IAC 16.2-3.1</p> <p>Quality review completed by 30576 on June 30, 2016</p>	F 0000	<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>	
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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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F 0282 SS=D Bldg. 00	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <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 implement an intervention of padded side rails for a resident known to thrash in bed for 1 of 3 residents reviewed for following their plan of care. (Resident #24)</p> <p>Findings include:</p> <p>The clinical record for Resident #24 was reviewed on 6/27/16 at 11:45 a.m. The diagnoses for Resident #24 included, but were not limited to, spastic quadriplegia and seizure disorder.</p> <p>The 6/14/16 Nursing Assessment Face Sheet for Resident #24 indicated, "Behaviors Tracked: Spastic Thrashing as self-stim (stimulation)."</p> <p>An interview was conducted with the</p>	F 0282	<p>F282 Requires the facility to implement an intervention of padded side rails for a resident known to thrash in bed. 1. Resident #24 side rail padding was placed the side rail. 2. All residents have the potential to be affected. A complete audit was conducted ensuring all side rail pads were appropriately placed on the bed. No concerns were noted. See below for corrective measures. 3. The care plan policy and procedure and side rail use policy and procedure were reviewed with no changes made. (See attachment A and B) The staff was inserviced on the on the above procedure. Directive inservice was conducted for these policy by a member of HOPE. (See attachment C) 4. The DON or his designee will conduct rounds ensuring all care plan interventions regarding side rails are properly secured on the side rails. The DON or his designee will review five side rails</p>	06/28/2016

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	<p>DON (Director of Nursing) on 6/27/16 at 12:32 p.m. He indicated Resident #24 had a self injurious behavior of rocking in the bed. He indicated 17 years ago, she broke her humerus doing so. He indicated the facility used side rails and pillows to position her to keep her safe while in bed.</p> <p>The 4/18/16 care plan for Resident #24 indicated, "Resident is unable to voluntarily get out of bed and unable to prevent rolling from bed while positioned on side due to diagnosis of spastic quadriparis (sic), seizure disorder thus requires use of siderails to provide a safe environment and maintain highest level of functioning. Thrashes in bed, tub and wheelchair. Hx (history) pathological fx (fracture)." The short term goal was for Resident #24 to be free of injury on a daily basis. Approaches indicated were for 2 full side rails to be up, and padded side rails at all times.</p> <p>The 3/16/16 Side Rail Screen for Resident #24 indicated the intent for her side rails was seizure precautions. It indicated, "Resident has seizure diagnosis and is at risk of seizures, making padded side rails necessary as a safety precaution.</p> <p>An observation of Resident #24 was made on 6/27/16 at 12:44 p.m. She was</p>		<p>daily for correct padding on rails. The DON or his designee will utilize the nursing monitoring tool daily times for weeks, then weekly times four weeks, then every two weeks times two months, then quarterly thereafter to ensure care plan interventions are being followed by staff caring for the resident until 100% compliance is obtained and maintained. (See attachment D) The audits will be reviewed during the facility's quarterly quality assurance meetings and the plan of correction will be adjusted accordingly. 5. The above corrective measures will be completed on or before June 28, 2016.</p>		

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	<p>lying on her back in bed. Two full side rails were up, one on each side of the bed. Only one of the rails was padded. The other rail was unpadded. The unpadded rail had 4 round, horizontal bars, with space between each of the 4 bars.</p> <p>An observation was made on 6/27/16 at 1:31 p.m. Resident #24 was lying in bed. There was still no padding on the one side rail.</p> <p>An observation was made on 6/27/16 at 1:55 p.m. with the DON. There was still no padding on one of the side rails. The DON indicated he thought the padding was supposed to be on the rail, and there should be a supply of padding for side rails.</p> <p>The Side Rail Use policy was provided by the DON on 6/27/16 at 2:46 p.m. It indicated, "If use is indicated, ensure side rails are up and secured prior to leaving resident's bedside."</p> <p>This deficiency was cited on May 12, 2016. The facility failed to implement a systemic plan of correction to prevent reoccurrence.</p> <p>3.1-35(g)(2)</p>			

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F 9999 Bldg. 00		F 9999	Notified ISDH SRSHelp desk on 7/7/16 per email as to no concerns documented on tag F9999. The reply to my email on 7/7/16 at 2:21pm advised writer to type in the response box N/A which will allow for the POC to be submitted.	06/28/2016	